



**Department of Health and Human Services  
Centers for Disease Control and Prevention  
Agency for Toxic Substances and Disease Registry**

**Tribal Consultation Advisory Committee (TCAC)**

**January 26-27, 2010  
Minutes of the Meeting**



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## Acronyms

AAIHB	Albuquerque Area Indian Health Board
AATCHB	Aberdeen Area Tribal Chairman's Health Board
AAT-PHEPC	Arizona Association of Tribal Public Health Emergency Preparedness Coordinator's
ACS	American Cancer Society
AzCPHP	Arizona Center for Public Health Preparedness
ADHS	Arizona Department of Health Services
AFN	Alaska Federation of Natives
AI / AN	American Indian / Alaskan Native
AI ATS	American Indian Adult Tobacco Survey
ALHOA	Arizona Local Health Officer's Association
ANMC	Alaska Native Medical Center
ANTHC	Alaska Native Tribal Health Consortium
ARRA	American Recovery and Reinvestment Act
ATSDR	Agency for Toxic Substances and Disease Registry
BIA	Bureau of Indian Affairs
BRFSS	Behavioral Risk Factor Surveillance System
CAB	Community Advisory Board
CBOs	Community-Based Organizations
CBPR	Community-Based Participatory Research
CDC	Centers for Disease Control and Prevention
CEEDs	Centers of Excellence in the Elimination of Health Disparities
CLC	Central Leadership Council
CPPW	Communities Putting Prevention to Work
CRCCP	Colorectal Cancer Control Program
CRIHB	California Rural Indian Health Board
CVD	Cardiovascular Disease
DACH	Division of Adult and Community Health
DASH	Division of Adolescent and School Health
DCPC	Division of Cancer Prevention and Control
DDT	Division of Diabetes Translation
DRH	Division of Reproductive Health
DHSP	Division for Heart Disease and Stroke Prevention
DIR	Division of Injury Response
DNPAO	Division of Nutrition, Physical Activity, and Obesity
DOJ	Department of Justice
DOR	Division of Oral Health
DSLRL	Division of State and Local Readiness
DUI	Driving While Intoxicated
DUIP	Division of Unintentional Injury Prevention
DVP	Division of Violence Prevention
EBCI	Eastern Band of Cherokee Indians
ELB	Executive Leadership Board
EPA	Environmental Protection Agency
FMO	Financial Management Office



FOA	Funding Opportunity Announcements
GDL	Graduated Drivers Licenses
GTHAN	Greater Tulsa Health Access Network
HHS	Health and Human Services
HIE	Health Information Exchange
HITECH	Health Information Technology for Economic and Clinical Health
HRAC	Health Research Advisory Council (HHS)
ICC	Incident Command Center
IHBN	Indian Health Board of Nevada
IHCIA	Indian Health Care Improvement Act
IH S	Indian Health Services
IOM	Institute of Medicine
IPV	Intimate Partner Violence
IRB	Institutional Review Board
ITA	Inter-Tribal Agreement
ITCA	Inter Tribal Council of Arizona
MCH	Maternal and Child Health
NACCHO	National Association of County and City Health Officials
NARA	Native American Rehabilitation Association
NARCH	Native American Research Centers for Health
NATIVE Study	Native American Time to Treatment Intervention Evaluation Study
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCAI	National Congress of American Indians
NCBDDD	National Center for Birth Defects and Developmental Disabilities
NCCDPPH	National Center for Chronic Disease Prevention and Health Promotion
NCEH	National Center for Environmental Health
NCIPC	National Center for Injury Prevention and Control
NDIC	National Diabetes Indian Coalition
NDI	National Death Index NDI
NDW	National Data Warehouse
NEPA	National Environmental Policy Act
NFPA	National Fire Protection Association
NHTSA	National Highway Traffic Safety Administration
NIHB	National Indian Health Board
NIOSH	National Institute of Occupational Safety and Health
NIMS	National Incident Management System
NMDH	New Mexico Department of Health
NNCTAPN	National Native Commercial Tobacco Abuse Prevention Network
NOHSS	National Oral Health Surveillance System
NPAIHB	Northwest Portland Area Indian Health Board
NPCR	National Program of Cancer Registries
NRF	National Response Framework
NVDRS	National Violent Death Reporting System
OADP	Office of the Associate Director for Programs
OCPHP	Office of the Chief of Public Health Practice
OCIFS	Oneida Community Integrated Food Systems
OD	Office of the Director
OMB	Office of Management and Budget
OMHD	Office of Minority Health and Health Disparities
OPHG	Office of Public Health Genomics
OSH	Office on Smoking and Health
OSI	Office of Strategy and Innovation
OSLS	Office of State and Local Support



OTA	Office of Tribal Affairs
PHAB	Public Health Accreditation Board
PHER	Public Health Emergency Response
PIMC	Phoenix Indian Medical Center
PPHR	Project Public Health Ready
PRAMS	Pregnancy Risk Assessment and Monitoring System
PRC	Prevention Research Center
REACH	Racial and Ethnic Approach to Community Health
RPMS	Resource and Patient Management System
SAMHSA	Substance Abuse Health and Services Administration
SES	Socioeconomic Status
SHSP	State Homeland Security Program
SIDS	Sudden Infant Death Syndrome
SDPI	Special Diabetes Program for Indians
SHP	School Health Profiles
SHPPS	School Health Policies and Programs Study
SME	Subject Matter Experts
STDs	Sexually Transmitted Diseases
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TAS	Treatment as a State
TCAC	Tribal Consultation Advisory Committee
TCCCP	Tribal Comprehensive Cancer Control Programs
THPS	Tribal Health Program Support
THRIVE	Teen Health Resiliency Intervention for Violence Exposure
TTAG	Tribal Technical Advisory Group
UNC	University of North Carolina
USET	United South and Eastern Tribes, Inc.
WFRS	Water Fluoridation Reporting System
WISQARS™	Web-Based Injury Statistics and Reporting System
WRIR	Wind River Indian Reservation
YRBS	Youth Risk Behavior Survey



**Centers for Disease Control and Prevention (CDC)  
Agency for Toxic Substances and Disease Registry (ATSDR)  
Tribal Consultation Advisory Committee (TCAC) Meeting**

**Minutes of the Meeting  
January 28, 2010**

**January 26, 2010**

**Opening Prayer / Welcome / Introductions**

**Kathy Hughes, TCAC Co-Chair  
Vice Chairwoman, Oneida Business Committee**

**Chester Antone, TCAC Co-Chair  
Legislative Councilman, Tohono O'odham Nation**

Chester Antone officially called the meeting to order, welcoming everyone and thanking them for their attendance. He then delivered the opening prayer. Kathy Hughes extended her welcome and gratitude as well, and subsequently led those present in a round of introductions. The participant roster may be found at the end of this document.

**Administrative Matters: Roll Call, Approval of Agenda, Approval of August Minutes**

**CAPT Mike Snesrud, Senior Tribal Liaison for Policy Evaluation  
Centers for Disease Control and Prevention (CDC) /  
Agency for Toxic Substances and Disease Registry (ATSDR)**

CAPT Snesrud conducted an official roll, establishing that there was a quorum of TCAC members present. She then called for approval of the agenda for the January 26-27, 2010 TCAC meeting:

**Motion: Approval of Agenda**

Reno Franklin made a motion to approve the agenda for the January 26-27, 2010 TCAC meeting. Mr. Finkbonner seconded the motion. The motion carried unanimously.



CAPT Snesrud then requested approval of the August 11 and 13, 2010 TCAC meeting minutes:

**Motion: Approval of August 11-13, 2010 TCAC Meeting Minutes**

Chester Antone made a motion to approve the August 11 and 13, 2010 TCAC Minutes meeting minutes, with minor edits to be sent to CAPT Snesrud, Co-Chair Kathy Hughes, and / or Ch-Chair Chester Antone. Mr. Trudell seconded the motion. The motion carried unanimously.

**TCAC Members Regional / National Updates**

**Overview**

During this session, TCAC members were invited to report highlights of new or critical public health issues occurring since the February 2009 meeting. The following members articulated that they would also be submitting reports in writing: Mr. Antone, Ms. Begay, Mr. Finkbonner, Mr. Franklin, Ms. Reft, Ms. Manuel Ms. Sebattus, Mr. Secataro, and Mr. Trudell.

**Updates**

**Derek C. Valdo**  
**Pueblo of Acoma**  
**Southwest Area Regional Vice President**  
**National Congress of American Indians (NCAI)**

Mr. Valdo pointed out that the National Congress of American Indians (NCAI) is involved in all issues in Indian Country, including health. Most of NCAI's recent work has focused on the issue of health care reform, with an effort to keep Indian provisions within the law, maintain the services provided by the Indian Health Service, and protect sovereignty within the bills that are being passed. NCAI can provide a legislative report to the TACA if so desired. Mr. Valdo reported that the current NCAI President, Jefferson Keel, was unable to attend this TCAC meeting as he was preparing for the State of Indian Nations Address in Washington, DC.

**Roger Trudell, Chairman**  
**Santee Sioux Tribe of Nebraska**  
**Aberdeen Area**

Mr. Trudell reported that Hepatitis C was on the rise in his region. The treatment regimen for Hepatitis C is long and largely unsuccessful because persons do not fulfill the treatment module. Childhood suicide is rampant in this area as well, as is obesity. Childhood and adult obesity prevention is very limited in this area and in all of the national budgets. He would like to see prevention and intervention addressed through a more thoughtful process. Without prevention or intervention, the back side is very costly. There are not enough funds in contract health services, and there never will be, to treat the continuing chronic illnesses in Indian Country.



Those who participated in the National Budget Formulation and Area Formulations understand this. The Aberdeen Area leads almost all other areas in most adverse statistics. Without prevention and a definite surge of funding for prevention and intervention, chronic illnesses in this area will continue to regress and IH S will not be able to meet the needs of all of the members of the direct service area tribes. Hopefully, TCAC and others can put forth an effort in prevention and intervention. The Aberdeen Area is finding that most Hepatitis C results from the sharing of needles, which means they are still not addressing the drug problems in the community.

**Joe Finkbonner, Executive Director  
Northwest Portland Area Indian Health Board (NPAIHB)**

Mr. Finkbonner reported that there continue to be health disparities in the Portland Area. They are fighting the fight as they typically have. However, since last the TCAC met, H1N1 has been the priority for the majority of their tribal efforts. There has been a wide range in how the tribes have been treated, including: 1) as true partners in health jurisdictions wherein vaccine was allocated directly to tribes from the state, 2) being invited to participate in general population vaccine clinics by the local health jurisdiction, or 3) as clinical providers rather than as sovereign tribal health jurisdictions, with an inability to make local priority decisions about who would be vaccinated. The final vaccine uptake results should reflect which system worked best. Anecdotally, Mr. Finkbonner anticipated that the tribe with the ability to engage in local decision making, which was treated as a true partner, would show a higher vaccine uptake than the other two models. Given that his uncle passed away the previous week, Mr. Finkbonner was unable to obtain the data regarding uptake as he was spending time with family, but he indicated that his staff was working to compile these data as quickly as possible.

**Dee Sabattus, Interim Director  
Tribal Health Program Support (THPS)  
Nashville, United South and Eastern Tribes (USET)**

With regard to the United South and Eastern Tribes (USET), Ms. Sabattus reported that she and Mr. Valdo had been working diligently on health care reform and the Indian Health Care Improvement Act (IHCA). USET's main priority recently for the tribes has been the effort to get H1N1 vaccines to tribal members. USET is also leading the national effort for Indian Country in applying for a \$30 million grant under the Health Information Technology for Economic and Clinical Health (HITECH) Act component of the American Recovery and Reinvestment Act (ARRA). This funding would be utilized to establish American Indian National Health Information Regional Extension Centers. Another critical service USET provides to tribes is Epi Reports. Some of this year's reports include: Diabetes Audit Report, Cost Analysis, Hypertension, and Community Health Profiles. These reports are provided to tribes at each board meeting. One of USET's current projects is the Infant and Adult Mortality Project. Originally USET was funded through the CDC Racial and Ethnic Approach to Community Health (REACH) program to establish this program. The emphasis is on infant mortality and creating birth and death registries. One of the challenges has been acquiring data sharing agreements through the states. When USET first began this program, they had to purchase all of the state data from states, which was rather costly. They have been successful in entering data sharing agreements with some states. USET's Maternal and Child Health (MCH) Project has grown in scope. Originally, the MCH Project focused on describing the MCH status within the Nashville area. However, USET has been working with the University of Arizona and the University of Kentucky to develop an education and training program for tribal health department staff to





certify them in MCH health activities, which would also give them credit toward a Masters Degree at either of those two universities. Ms. Sebattus indicated that USET provided information to NIHB to post on their website if anyone was interested in further information about this program. The Data Quality Assessment Project has been underway for a couple of years. Examples of reports that this project has established include: Disease-Specific Data Quality Assessment Projects that will compare Tribal Resource and Patient Management System (RPMS) data to the National Data Warehouse (NDW) data to determine how it differs in order to inform tribes about changes needed in entering data and where data are lost.

**J.T. Petherick, Health Legislative Officer  
Cherokee Nation, Oklahoma City Area**

Mr. Petherick indicated that the Cherokee Nation / Oklahoma City area includes Oklahoma and Kansas Tribes, and one tribe in Texas. Many exciting efforts have been taking place in the Oklahoma City Area. One effort that the Cherokee Nation is proud of, and is committed to working on with the tribes in their area and nationally, is that they are one of the Public Health Accreditation Board (PHAB) beta test sites along with the Navajo Nation and the Keweenaw Bay Tribe in Upper Michigan. The kick off meeting was convened in November 2009 in Washington, DC so they are still learning about the process and all of the requirements. Mr. Petherick explained that the PHAB accreditation process, currently in its infancy, is essentially to ensure that various government agencies are carrying out the primary components of public health. City, county, and state agencies are participating in the PHAB process in addition to tribes. Understanding their differences and how they can all work together is highly important. While it will take a considerable amount of work to address the PHAB accreditation criteria, the process will highlight areas in which Indian Country is successful, where improvements are needed, and what partnerships should be developed with city, county, and state health departments. The Cherokee Nation / Oklahoma City Area has also been heavily involved in the H1N1 response. It has been their experience, as is the nature of the epidemic, particularly on the tribal side, that they had fight to be involved in the process and for resources at the beginning, but later were overwhelmed with vaccine and could not give it away.

The Cherokee Nation is a fairly large health system compared to a lot of other tribes, yet they had to advocate and fight to be involved in the process at the state level. For the most part, the State of Oklahoma is fairly receptive to working with tribes when the Cherokee Nation initiates conversations. However, it is always a challenge. Tribes in Kansas typically have a much more difficult time work with the state, which seems to be a population issue. Tribes in Texas have a very difficult time working with the state. Oklahoma and to some extent Kansas, have been involved in developing the statewide Health Information Exchange (HIE) programs for their states through ARRA funds. This involves various health systems and jurisdictions, and all of the complications that arise with that. Getting states and non-governmental health providers to understand what it means to work with Indian Country is always a challenge. The Cherokee Nation has been fortunate to already have been involved in HIE in Northeastern Oklahoma. They initially applied together with ARC to develop and HIE, so they believe it is a model that can be shared with all of Indian Country and the rest of the nation. Now they are beginning to work with Tulsa, which is a metropolitan area near their jurisdiction, as well as with the Creek Nation. This is called the Greater Tulsa Health Access Network (GTHAN), which is developing an HIE in Tulsa. A lot of the contract health dollars are allocated to Tulsa, so they are very excited to be a part of this effort and the statewide efforts as well.



The Cherokee Nation is close to finalizing the announcement for a new Epidemiology Director of their Epidemiology Center. There have been challenges over the last few years getting someone in place and getting them to stay. They hope to have someone in place who will stay long-term to work on many of the issues the Epidemiology Center has been created to carry out, but simply has not had the staff in place to do so. One of those efforts is data sharing issues in the Oklahoma City Area that have been difficult to overcome. One issue that affects the Cherokee Nation, but does not directly impact them, is the funding crisis being experienced by states. States are facing major budget crunches, which are likely to impact public health and trickle down in terms of how states work with tribes. It is important to be aware of this issue and determine what to do about it. In closing, Mr. Petherick informed everyone about the Cherokee Nation Cancer Summit to be convened March 3-5, 2010 in Tulsa, which is open to anyone who chooses to attend. Unfortunately, this summit is at the same time as the HHS Budget and Policy Consultation Meeting in DC.

**Roselyn Begay, Navajo Nation  
Division of Health, Program Evaluation Manager**

Ms. Begay reported on behalf of Ms. Ecoffey, who was attending the Navajo Nation Council in session this week. She also recognized their Epidemiologist, Dr. Deborah Klaus, who is the Navajo Epidemiology Center Director. The Navajo Nation Council considered very important legislation for a commercial-free tobacco act during the past fall, which unfortunately failed passage. The Navajo Nation worked with a number of organizations in the Navajo Nation and also from South Dakota to outlaw commercial tobacco on the Navajo Nation. Since that time, this was assigned to the Navajo Division of Health to work closely with a number of organizations to reintroduce that legislation to the Navajo Nation Council. Their Division Director for Health has urged staff to closely coordinate and work with the legislative body to reintroduce similar legislation for the 2010 summer session. Another public health law that was updated with the Assistant of the Epidemiology Center and the Navajo Health Education program is about a 10-year old or so policy that the Navajo Nation approved regarding HIV / AIDS. They are hopeful that this updated legislation will be submitted to the Navajo Nation Council in the spring of 2010.

The Navajo Epidemiology Center has been involved in a number of efforts, including H1N1. Across Indian Country, all of the tribes have played an active role in the H1N1 effort. Ms. Begay acknowledged Dr. Klaus for her keen role in making sure that daily information was disseminated and coordinated throughout the Navajo Nation, including IHS and various tribal programs, on H1N1 activities. The Navajo Epidemiology Center also coordinated through the Incident Command Centers (ICC) with data and other information pertaining to the Navajo Nation. Dr. Klaus also served as a liaison with the State Department of Self Health and CDC. The Epidemiology Center also coordinated the Breast and Cervical Cancer Screening Program. Of the 360 breast screenings, 17 were detected to be abnormal. Of the 1,000 cervical screenings, 63 were detected to be abnormal. This is a very important program, and the Navajo Nation applauded CDC for funding this program and requested continuing support. In the Community Health Representative (CHR) program, 36 CHRs attended an Introduction to Public Health and Community Health Assessment Training at Diné College, a local tribal college located in Tsaile, Arizona. This is a pre-requisite to a Public Health Certification Program. Another 9 CHRs earned Public Health Certification through the Diné College and the University



of Arizona College of Public Health. Essentially, this program evolved through a Native American Research Centers for Health (NARCH) program years ago. The Bioterrorism Program works very closely with the Navajo Area IHS and other tribal programs. In October, they staged a one-day mass vaccination event during which over 18,000 individuals were vaccinated. The Bioterrorism program also worked very closely with the Head Start and Navajo Area IHS to vaccinate children against H1N1 influenza. This program has spent an extraordinary amount of time with the Public Health Awareness Program regarding H1N1 and seasonal influenza through a variety of media and venues.

As noted, the Navajo Nation is one of the tribal sites that was selected to participate as a beta test site for the PHAB accreditation process. They are also preparing rigorously to conduct a self-assessment, and have recruited and established an internal advisory team. However, with the recent snow and wet climate in their area, a majority of the Navajo Division of Health programs (e.g., CHR, Bioterrorism, Health Education, Aging, and others) are very much involved and serving at the frontlines to help Navajo people who live in remote areas to assure that they are okay, have accessible roads for emergency and public safety vehicles, et cetera. Therefore, the beta test site activities were placed on hold.

**Lester Secatero, Chairman  
Albuquerque Area Indian Health Board (AAIHB)**

Mr. Secatero reported that one of his communities recently experienced two suicides. He explained that New Mexico is currently a half a billion dollars in the red. The state legislature is seeking to take by some of the funds they allocated to tribes in an effort to balance the state budget. Although there is a very nice train running from Santa Fe to Albuquerque, it will cease running in approximately one month if they do not locate \$700,000. The way the state plans to determine who owes money is that the associations and counties will be releasing their capital outlay reports. Based upon those reports, some of the tribes will likely have to return funds. There are now 20 Pueblos in the Albuquerque Area, with Ysleta del Sur Pueblo joining from El Paso. The Pueblos provided a list of priorities for the Albuquerque Area to NIHB in CD and also to the Obama Transition Team. They are closely monitoring the Indian Health Care Improvement Act. AAIHB has finally hired an Executive Director after being without one for about six months. They have had a difficult time keeping Executive Directors, who tend to leave after short periods of times. One never bothered to show up in the first place. They are hopeful that the new Executive Director, Loren Sekayumptewa, used to be in Gallup where he ran an alcohol and substance abuse program. AAIHB is constantly seeking funding. They submitted a breast and cervical cancer request to the Health Promotion and Disease Prevention through the Alliance for Healthier Generations, but this was not funded.

Recently, Congressman Harry Teague from the House of Representatives attended an AAIHB board meeting. AAIHB requested everything they could possibly think of from Congressman Teague while they had his attention. They informed Congressman Teague that instead of waiting for IHS to build them a clinic, they built their own clinic through grants and loans totaling \$3.4 million within a couple of years. They explained to Congressman Teague that while they were able to accomplish this, they were unable to staff this high tech clinic. They requested another \$700,000 to supplement the funding for the clinic and also have approximately \$385,000 in funds just sitting. It is very difficult to acquire funds because it has to be funneled through the Navajo Tribes, so they have been waiting for a long time for medical equipment. According to a survey Mr. Secatero read, the cumulative cases for HIV for the state is 279 for American Indians and Alaska Natives. People are finding out about the new Canoncito Health



Clinic, and every year hundreds of new charts are completed. Albuquerque is slowing down on their dental services, and the nearest hospital is ACL, which is also slowing down. Thus, Canoncito Health Clinic has an overflow. They informed Congressman Teague that the facility needs an additional full-time medical doctor, full-time registered nurse, full-time pharmacist, part-time dentist, part-time psychologist, part-time social worker, and part-time optometrist plus the additional funding of \$700,000. Mr. Secaturo could not get into the dentist because so many people are waiting, which he said was why he sat before the TCAC with a toothache.

AAIHB is working closely with the New Mexico Department of Health (NMDH), with regularly scheduled meetings and trainings. They have H1N1 training and disability services for children. They discuss data sharing agreements. They have a liaison position between the NMDH, the Tribes, and IH S and she is doing a super job. The AAIHB has also been a contracting agent for the Veteran's get together every November, which has large turnouts of people who travel from as far as Oklahoma. They conduct health screenings during this time, and various agencies come together, with IH S and the VA Hospital taking the lead. The Albuquerque Area has also established an Institutional Review Board (IRB), which was approved October 1, 2009. On this IRB are two doctors, a scientist, and two community members. This IRB was formed because AAIHB had to submit everything through IH S Headquarters. For Navajo Chapters in the Albuquerque Area, they still have to go through the Navajo Nation IRB. It is said that the AAIHB has contact with over 100,000 American Indians from 27 Tribes. They have plans to expand, and are getting to know the Denver Urban Center fairly well, are working with Texas, and are really going to work on the Albuquerque Urban Center.

With respect to epidemiology, AAIHB has a couple of on-going projects. One of these is the 2009 Southwest Tribal Youth Project Schools. Data collection is conducted at middle and high schools among American Indian Youth. This has been done with 22 schools total. Another project, which is funded by CDC, is the Southwest Tribal Behavioral Risk Factor Surveillance System (BRFSS). They conduct community assessments in person and by telephone. There must be tribal-approved training and data collection assessments to identify and prioritize health needs. Their NARCH-5 is good until 2013 and they should soon receive notification about their NARCH-6.

**Cynthia Manuel, Councilwoman  
Tohono O'odham Nation  
Indian Health Board Tucson**

Ms. Manuel indicated that she had been out for a while because she was hit by a truck, but made it through and was very happy to be back. She reported that NIHB, through a cooperative agreement with CDC, had been able to disseminate information through various mechanism such as the *NIHB Washington Report* bi-weekly newsletter that provides updates on current legislative issues, health care reform, the Indian Health Care Improvement Act; the *NIHB Health Reporter* that is published quarterly and includes updates and information on upcoming events throughout Indian Country; *NIHB Health Alerts*; *Restoring the Balance* tribal public health brochures, which are sent to tribes to help them understand the importance of public health; information on H1N1; NIHB listserv; a TCAC yearly calendar; the Tribal Public Health Accreditation beta testing; technical assistance to the Advisory Board; and the Save the Date for the Public Health Summit to be convened May 18-20, 2010 in Albuquerque. NIHB continues to make the H1N1 health issue a priority in Indian Country. For her tribe, this continues to be an issue because they live right on the border with Mexico. Many illegal immigrants cross the 75-mile international boundary that runs through the reservation. The activities being planned are



the beta testing data collection and the summit as mentioned. The theme for the summit is “A New Decade of Indigenous Public Health.” The summit will offer additional training opportunities for evaluation and grant writing. On September 30, 2009 was the close of the Healthy Indian Country Initiative and the resource guide will be published in February 2010. Dissemination of the *Restoring the Balance of Tribal Public Health* brochure began in late 2009 and has disseminated over 5,000 copies of brochures to the Tribal Health Centers, Directors, Tribal Epidemiology Centers, and IHS facilities. A second dissemination is planned for the broader population.

**Reno Franklin, Chairman  
California Rural Indian Health Board (CRIHB)**

Mr. Franklin recognized staff members who traveled to Atlanta to assist him in answering any questions posed regarding California issues. He stressed that the CRIHB has great staff and quipped that he was fortunate to have stolen some staff from Mr. Finkbonner’s area who clearly saw the light and beauty of the California weather. California has a number of issues, one of which is the weather, which does wreak havoc on them (e.g., El Nino every 10 years, a tornado, et cetera). It seems whenever there are state of emergency declarations in California, they are for everyone except the tribes. This is an issue when many people are dependent upon medications that CHRs drive out to their areas. People cannot receive medication refills when there are no roads.

Regarding H1N1, California has 110 federally recognized tribes. CRIHB was asked to go to the state to request Public Health Emergency Response (PHER) funds. Mr. Franklin said he was not really sure how that worked because CRIHB submitted a great application for PHER funding. Written by Dr. Kim, the application was basically to track H1N1 (e.g., surveillance), mini-grants to tribal health programs that would offer after hour vaccine clinics, the creation of culturally competent materials to address social distancing, a culturally competent media campaign (e.g., brochures, PSAs, et cetera). The state still has not responded. Tribes are told that if they want PHER funds, they should work with their states and counties. However, California could care less. Although these funds were earmarked for tribes, the state keeps them. California is broke and does not want to give up any funds, yet tribes are being asked to go to them for what is rightfully theirs. Another issue is that California told the tribes to work with their counties, which have no concept of consultation or any desire to consult with tribes if it is not going to center around the county gaining something out of it. California has 52 counties, zero of which have engaged in consultations with tribes. Not a single county has consulted with tribes in its area. Not one of the counties has stepped up to offer assistance. Some areas in California cannot give away the H1N1 vaccine. His own county, Sonoma, is flooded with H1N1 vaccine while the county right next to them, Mendocino, has people dying because they are not able to access vaccine.

This issue is being created by whomever has control of vaccine supply and disbursement. Another problem in California is that their Epidemiology Center does not have any data sharing agreements. There is no standard protocol for Tribal Epidemiology Centers to access data. This is extremely problematic in California. If the Area Office would spend as much time worrying about how to get more funds for California as they do worrying about how they are not going to share data with the Tribal Epidemiology Center, they would be much better off. These agreements are desperately needed, and the tribes should probably form a support group in the form of a lawsuit. If they are denied access, particularly on foolish reasons, there should be some intermediary to whom they can turn.



## **Chester Antone, TCAC Chair**

### **Councilman, Tohono O'odham Nation, Tucson**

With regarding to disseminating information, Mr. Antone reported that the Tohono O'odham Nation contacts tribes in the area, and relies mainly on the listserv that CDC, NIHB, and NCAI send information out on. The Tohono O'odham Nation now ranks number one in diabetes, which they are not really proud of. They are trying to do all that they can to try to combat that. Their Wellness Center opened January 12, 2010, the purpose of which is to try to get people to be more active because they realize the importance of taking their medications, eating right, and exercising to reduce diabetes.

Unfortunately, five Tohono O'odham Nation individuals took their own lives. Suicide is a major issue that they have, which goes against the tribal philosophy that the Creator gives life and should be the one to take it back. They are trying to deal with this situation, and are trying to use the State Regional Behavioral Health Authorities, because they are access eligible through Medicare / Medicaid to qualify for services for crisis intervention. They take people no matter what.

Mr. Antone indicated that the next Friday he was supposed to play in a basketball game. The Tohono O'odham Legislative Council challenged a game with the San Simon Health Center staff. San Simon began operations a year ago. Building this facility was a joint venture between the tribe and IHS, and the facility has been staffed. This is an important collaboration between IHS and the tribe. The basketball game will occur for the grand open for Behavioral Health Services that relocated there. The nation overall is trying to decentralize services, so Behavioral Health Services now has a location within the IHS facility so that referrals can be made directly within the clinic. Also in this facility are Health Transportation and Adult Protective Services. They opened a shelter for adult citizens who may be in situation where they need protection, which has 12 beds (6 for women and 6 for men). The second one they are going to work on is in his district in the west. They plan to turn one of the rental homes there into a Senior Center Protective Center. Unfortunately, there is a lot of alcoholism, drug abuse, et cetera. The whole culture has turned around such that elders need protection, particularly around the 1<sup>st</sup> or the 3<sup>rd</sup>. It is unfortunate that they now have to provide this.

With respect to public health preparedness, they are working with Pima County and the Mexican Government on a tri-national plan to address emergencies. The Domestic Affairs Committee is addressing that. This also addresses the health component due to H1N1. A lot of the early incidents of H1N1 came from Mexico. With 75 miles of that border that is wide with no cities, this is important to be aware of. H1N1 education has been done pretty much throughout the nation ever since it began, and more importantly because of the recent letter sent by Dr. Sebelius regarding the Native American community being most hard hit. Overall, the mission has had a pretty good relationship with Pima County and the Arizona Department of Health Services. Early on, they conducted a lot of public relations through the radio. They have been doing this so much that the Health and Human Resource Development Committee, which Mr. Antone sits on, will occasionally visit the schools to meet with the administrators to learn how things are going. They went to the Santa Rosa Boarding and Day School, and he was surprised because when they walked in the halls they saw many posters regarding how to prevent H1N1, and children's posters. It made him feel good that the message was getting through. One issue



regarding public health information is that somehow, they completely missed out on the debate over mercury nasal sprays until much later. There was a concern regarding H1N1 vaccine, particularly for pregnant women. It was later disproven, but astoundingly they did not know.

They have a fair coming up soon, during which they conduct the Red Dress Fashion Show to inform about cancer and are going to include men this year. They also have a one half marathon.

In closing, Mr. Antone said that TCAC should be aware and at forefront of the organizational changes occurring at CDC. TCAC should be aware of recommendations that were made previously and where they will be addressed within this reorganization, because they no longer have the Executive Leadership Board or the Central Leadership Council. He understood that this was where most of the TCAC's recommendations were previously forwarded to be worked on by Dr. Bailey who mentored them. TCAC really needs to know where those recommendations will go and by whom they will be addressed. He thought this was one of the most important things they needed to consider. A lot of the centers have their charge already, so TCAC must determine which ones they need to concentrate on.

**Alicia Reft**  
**Alaska, Karluk Ira Tribal Council**

Ms. Reft indicated that there was not a great deal to report since August. She expressed gratitude to those who made it to TCAC meeting convened in Alaska in August 2009. She noted that while she was with the Karluk Ira Tribal Council, her report was coming from the Alaska Native Tribal Health Consortium (ANTHC) in Anchorage.

Regarding hepatitis and liver cancer, ANTHC has had a successful Hepatitis B Program over the last 25 years. One of their providers, Brian J. McMahon, MD, contributed to a recent Institute of Medicine (IOM) report titled, *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*. CDC has been supportive of the work related to Hepatitis care in Alaska. [Citation: IOM (Institute of Medicine). 2010. *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*. Washington, DC: The National Academies Press]. This report is also available on the IOM website.

With regard to sexually transmitted diseases (STDs), the rates of STDs, particularly Chlamydia, remain high in Alaska. This past winter, the website [iknowmine.org](http://iknowmine.org) was launched as an innovative way to reach teens and young adults with sexual health information. Some of the goals include encouraging testing for STDs, including rapid testing, partner notification, and increasing awareness and education via technology that teens can relate to.

In terms of H1N1, it was anticipated that the annual meeting of the Alaska Federation of Natives (AFN) would be a place where H1N1 would be transmitted, given that thousands of Alaska Native people attend this meeting each fall. The ANTHC system offered innovative ways to educate about H1N1 prior to people leaving their villages or regions. These included use of social media tools and video / audio public service announcements.

Pertaining to suicide prevention, northern regions in Alaska had some of the highest suicide rates in the nation. Recently, the Behavioral Health and Injury Prevention Programs worked together to convene the first Alaska Suicide Prevention Summit, which was well-attended by tribal leadership. ANTHC will continue to provide applied suicide intervention skills training.



Concerning the Alaska Native Epidemiology Center, cancer is a leading cause of death among Alaska Natives. Colorectal cancer is the most diagnoses cancer. The Epidemiology Center Director, Ellen Provost, has recently completed her last breast cancer chemotherapy treatment. She has been a model EpiCenter Director and model patient. During the AFN this year, they had a super colon, which people could walk through to make the point that this disease is preventable, treatable, and bearable. This is a wonderful program and people in her area are finally being treated for colorectal colon cancer.

**Kathy Hughes, TCAC Co-Chair  
Vice Chairwoman, Oneida Business Committee**

Ms. Hughes indicated that she represents the Bemidji Area, which includes Minnesota, Wisconsin, Michigan, and Iowa and encompasses 35 tribes. Unfortunately, it seems like their health priorities never seem to change. These continue to be diabetes, cardiovascular disease, cancer, and obesity. Some changes are occurring recently, however. They are observing a continuing increase in youth obesity. Some of the national studies are reflecting this as well. They began programs in the school in Oneida in K-12 and Head Start pertaining to nutritious foods and teaching youth about healthier snacks. They have their own Oneida Community Integrated Food Systems (OCIFS) and their own farm and herbal market. Through OCIFS they are trying to introduce healthy snacks and healthy meals to the school system. In the last two years, they have had Oneida Black Angus Beef that they can now serve in the school. In the Head Start program, they have changed Halloween to a healthy snack event. Instead of giving out candy, they now provide healthy snacks such as goldfish, graham crackers, et cetera. A three- or four-year old does not really notice. They are just excited about going around and getting something in their bag. With youth obesity is that now Type 2 Diabetes is being diagnosed at a younger and younger age. While there is an elder group in which they are maintaining and getting diabetes under control, now another generation is beginning to have diabetes, which did not occur before. They are controlling it at one end and losing it at the other. The focus is still prevention and maintenance, but is moving from the elder to the youth population. This is unfortunately, but hopefully they will get this under control much sooner with the younger group. It is also an indication that they need to make some changes to how they are approaching obesity and diabetes overall. They recently developed a calendar. Each page has information on nutrition and diabetes, and each month has a recipe. The Diabetic Team developed the calendar with funding from CDC. They also developed a medicine wheel, funded 100% by Merck, which includes a carbohydrate counter and the number of calories various types of exercise burn. Ms. Hughes shared examples of each of these items with those present. She thought they could accomplish much more with additional partnerships.

H1N1 was, of course, a very hot topic for their area as well. Similar to what was heard from others around the table, they still have vaccine left. They have gone through all of the priorities and held their last open clinic the week before. It was not clear to Ms. Hughes why everyone was not acquiring the vaccine. Though initially there was a concern about it being a new product and whether it was safe, she did not believe this was the major concern. Instead she thought that it was because H1N1 was not personal—they have not had an occurrence in the community that made it personal and increased interest in being vaccinated. However, a tribal employee died from H1N1. She was 24 years old, so she was in the high risk category. She worked in the casino. Because it was a very public facility, they did the best they could to downplay what was occurring, which perhaps also contributed to the number of people being vaccinated. It was good for business, but may have been bad for increasing the incentive for





people to get vaccinated. There has been a high occurrence of H1N1 in Wisconsin, so it is believed that there will be a third wave.

Wisconsin recently passed a state law for a statewide smoking ban in all public facilities, which goes into effect in July 2010. This is a Catch-22 for the tribes, especially for Oneida, because tobacco sales is one of their higher revenue generation businesses. They are concerned about the health of their tribal members and employees, but they cannot afford to lose any revenue. The economy affects the tribes even more so because they are also short in the beginning, so having the economy in a slump makes it much more challenging. There is probably no state in the country that does not have a deficit budget. Some are much larger than others, but if something is not done, every tribe will be in the same situation. Tribes are trying to obtain funding from states that are already trying to figure out ways to not allocate more funds, especially to tribes. This will continue to be a problem. Oneida has not yet determined how they plan to deal with the smoking ban. They are working on a tribal law that will implement a smoking ban in part in some public facilities, but they are trying to protect the casinos to keep smoking available there.

In Wisconsin, data sharing is an ironic situation. In Wisconsin, there are 11 tribes. It is the State of Wisconsin who is trying to get the state to sign data sharing agreements. This differed somewhat from what she had heard others around the table say. Oneida has signed that data sharing agreement. She indicated that she would provide a copy of that agreement as a sample for everyone else. In a meeting Ms. Hughes attended the week before, the Wisconsin State Medicaid Director indicated that of the 11 Wisconsin tribes, 4 had signed the agreement to date. She told him she would assist in getting the other tribes to sign on as well.

They have excellent consultation programs in Wisconsin and Minnesota. Michigan is struggling somewhat, but is beginning to improve in some areas. Wisconsin meets twice a year with the Secretary of Health Services for the State of Wisconsin. If they have any issues any other time during the year, they have no problem getting a meeting with the Secretary. They are currently working to finalize a long-term care agreement. There was recently a meeting on Oneida, and there will be a couple more meetings, but Ms. Hughes said she hoped that the long-term care agreement could be finalized within the next couple of months. The long-term care agreement is important because it extends services for which they will be able to receive reimbursement from the state for in-home care primarily. They do have a nursing home and are trying to acquire reimbursement for some of those services as well.

Ms. Hughes said she thought the organizational structure occurring within CDC was an issue with which the TCAC should become very familiar. While they were receiving information as the discussions were taking place, she did not know whether the TCAC had sufficient input on the organizational change, and she was extremely surprised to find out the week before that it was published in the December 28, 2009 *Federal Register*, but was not published for comments. It was published as a done deal. In reviewing that organizational structure, she believed that the TCAC had really lost ground and that the relationship they were trying to formulate with CDC was taking a step backwards under the new administration and new organizational structured.



With that in mind, she expressed her hope that during their time in Atlanta, they would have more opportunity to discuss this, particularly in terms of speaking to Dr. Frieden directly about the organizational structure and the lack of consultation before putting the new structure into place.

Regarding the Census, which would begin in April, Ms. Hughes stressed the importance of tribes getting their people counted. CDC is one of the places where this is most important because CDC funding is based on population numbers. Tribes are already short on funds. From an Oneida standpoint specifically, the 2000 Census has their numbers at a little over 700 yet they have over 16,000 members. Tribes must take responsibility for helping to ensure that their numbers are counted accurately.

### **Discussion Points**

- Mr. Franklin agreed with the reorganization issue, and articulated how disappointed he would be if tribes were dropped into an Office of State and Local with no Tribal listed in the office name. This will be a slap in the face for all tribes. Therefore, he expressed his hope that they would hear that this was a foolish mistake that would be changed.
- Ms. Hughes said she did not know of any place where there was this type of relationship between tribes and counties. Their protocols simply do not take them to that level.
- With regard to the organizational improvement process, Dr. Bryan responded that it had been interesting and it was just now occurring to him that the public input on this process did not take place the same way it did during the prior reorganization process several years ago. He pulled up the *Federal Register* announcement to review it again, and concurred that it was basically an acknowledgement that this was occurring, and it occurred on an internal basis fairly quickly. He said he thought those were reasonable questions to ask Dr. Frieden, although he did not believe the lack of public input was limited to tribal input. It seemed to be more broad, but the infrastructure was something that needed to change quickly, though he said he would leave that for Dr. Frieden to speak to. Dr. Bryan said he thought it was also important for the CDC leadership to hear the TCAC's concerns about the visibility of a Tribal office and where it sat within the organizational structure. On the other hand, he thought it was important for them to know what had been occurring behind the scenes in terms of what he and CAPT Snesrud observed as a new level of very visible support and interest in bringing together a tribal unit that extends beyond two tribal liaisons and that builds some staff and fiscal support to do the things that they have struggled to do from year to year with just two people. That support is tangible, real, and put him and CAPT Snesrud in a more optimistic frame of mind than they have been in many years about that. There are practical issue with regard to where a unit would sit organizational that has to do with the fact that the further a group is "up the food chain" the less the opportunities for building structure with staff and a larger budget due to the constraints around how OD offices are funded and staffed. Dr. Bryan said he did think it was a good discussion to have, and that the juncture was immediate. He and CAPT Snesrud met the previous day with Karen White who is heading up the Office of State and Local Support (OSLS). State and Local means Tribal and Territorial. It is not in the name, but that is what it means. That was a clear message from Dr. Frieden as this new office was formed. They wanted to move the tribal activities within OD out of the minority health umbrella and more in the mainstream of government-to-government relationships. That was done by design because they really



wanted to put Tribes on the same level with State and Local, so Tribal is going to add its own box wherein it is institutionalized in the agency that whenever they were talking about State and Local, they were talking about Tribal governments as well. He thought that there was still time for input. On a very short timeframe between this meeting and may, he and CAPT Snesrud were charged to work with OSLS to think through what the strategies would be for this new unit and for Indian Country involvement across the agency. While there was a lot of momentum going on, that did not preclude the need to ask the hard questions.

- Ms. Hughes said she knew that with CMS and the Tribal Technical Advisory Group (TTAG), it was never dreamed when that advisory group got together that they would be formalized statutorily. They are the only tribal advisory group that is statutorily created. Funding and getting any support were always an issue. They began with only one person, and they have staff who are able to assist with the work flow. She expressed her hope that with discussion. They could garner the proper support for the TCAC. They are responsible for Indian Country and for acquiring the funding needed for Indian Country from CDC. She personally believes that this relationship is still so new that there are areas of the CDC that they have not even tapped. She said that knowing that Oneida had actually received quite a bit of CDC funding, though other tribes could not seem to crack open that door. This is very difficult because everything is competitive with CDC, and many of the tribes do not have the administrative skills and support to be able to write the applications. Technical support is extremely difficult to come by, as are the data that are needed to be able to compete for these funds. Many challenges remain for the tribes in terms of working with CDC.
- Dr. Bryan thought that the session on Thursday would offer a great opportunity to address H1N1. He expressed his hope that during the H1N1 timeframe, they would hear the good, the bad, and the ugly. A number of lessons have been learned, some of which are very positive, and others of which have been more challenging and frustrating and have varied from region to region. H1N1 activities were winding down, and there was less concern with a third wave as all of the indications were that vaccine uptake / coverage across the country was approaching levels consistent with herd immunity in many places. However, there were still isolated pockets of activities, which could have more impact on more rural Indian communities in the future. This highlighted the need for continued emphasis on distributing vaccine and increasing coverage in areas where there may not be herd immunity. This should be treated as a preamble to what still could be a major pandemic, or avian influenza, or anything else that arises next. Because they had people's attention, it was the right time to talk about what lessons were learned and how things could be fixed for the future. The other recurring theme he heard pertained to data sharing. Dr. Bryan stressed that they wanted to be the tribes' advocates with their colleagues at the IHS, but was somewhat limited in what they could do in that capacity. Though he was not sure what the problems and fixes would be, but thought that they could do more on the CDC side if the issues were with the state where they might have more leverage in terms of negotiating and working on tribes' behalf in terms of data sharing. He stressed that the more specifics they had on this, the better on the federal or state side.
- CAPT Snesrud added that her recollection was that when they were planning for the August 2010 TCAC meeting, they identified the need to have a specific focus on data sharing during a TCAC meeting. Perhaps as they looked toward the next meeting, they could consider adding this to the agenda and bringing in key representatives to dialogue with the TCAC, including IHS representatives and state colleagues. If they were very intentional, they could have the kind of in-depth conversations they needed to. In addition, she reminded everyone



that their previous dialogue with Dr. Bailey regarded developing a site where they could host TCAC related materials. This has been set up, but with the reorganization changes at CDC and health care reform issues, they had not launched it yet. This is an FTP site to which the primary and alternate TCAC representatives will be given passwords. She is in the process of setting that up so that they will have fairly complete files for each meeting back to 2007. The representatives would also have an opportunity to post information from their Area Health Boards or Tribal Epidemiology Centers. The site will not have interactive capabilities, but there are mechanisms that they could use as they continued to improve their connectivity, such as a blog. They have relied heavily on NIHB and will continue to do so with their permission and assistance with circulation / dissemination of information.

- Ms. Hughes added that there is also another source on the internet that can be used for sharing of data and communicating back and forth, which she indicated she would provide to CAPT Snesrud.

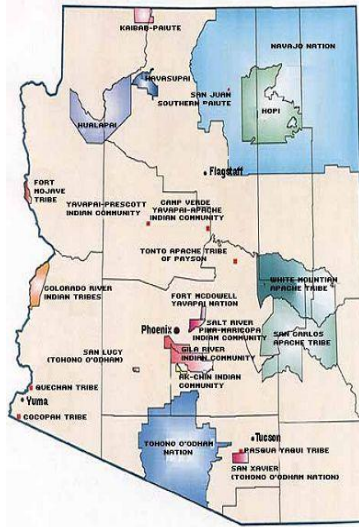
## Arizona Tribal Public Health Preparedness Strategic Plan

**Luke Johnson**  
**Fort Mojave Indian Tribe**  
**Public Health Emergency Preparedness Coordinator**

**Brenda Granillo, Director**  
**Arizona Center for Public Health Preparedness**

Mr. Johnson indicated that he was from one of the 22 Arizona tribes, and that he and Ms. Granillo were there to present information to the TCAC on work that they are doing in Arizona. Arizona is a very progressive state tribally. With regard to the Environmental Protection Agency (EPA), Region 9 is always a trendsetter for all of America. The tribes in Arizona are also the trendsetters for Region 9. There were very interesting comments earlier in the day about the H1N1 vaccine problems occurring in California and other areas. This is different in Arizona. When Janet Napolitano was the Governor of Arizona, she stated that all Arizona Departments were to have a consultative agreement with tribes, and they did this. This included Arizona Department of Health Services (ADHS) that the PHEP Coordinators work with. They have an extraordinary relationship compared to what is occurring across American with Tribes. Based on that, Arizona Indian Tribes in the PHEP programs enjoy a very unique relationship with the State of Arizona in the H1N1 work. To improve upon and enhance that, the State of Arizona ADHS program appoints a tribal representative who is called the Tribal Preparedness Coordinator. They have contracted that with the Fort Mojave Indian Tribe, the tribe to which Mr. Johnson belongs. So his office enjoys the privilege of going to all of the reservations in Arizona to work with all of the PHEP Coordinators in the advancement of their PHEP H1N1 programs.

A collaborative team effort that they have in place, that is comprised of a body of five tribes that represent all Arizona PHEP Coordinators, decided in May 2009 to develop a strategic plan for all of the Arizona PHEP Coordinators and their work that would be consultative to the ADHS. The following map reflects where some of the tribes are located:



Some of the tribes are quite large, with the Navajo Nations being the largest. Others are quite small. Tribes range from 60 to over 100,000 people, so they are quite diversified. Yet, all of these tribes in Arizona have come together as a PHEP program, and through a collaborative effort decided that they wanted this strategic plan.

Of the state land mass, 23% are Indian Lands comprising 31,615 square miles or 20,233,600 acres. Of the Arizona population, 9% are Native Americans. The ADHS PHEP program serves 178,846 people. Based on the demographics of tribal presence, Arizona has mandated each state department to implement a government-to-government consultation process. The Arizona tribal profile is as follows:

Arizona Tribal Profile			
Nations (4)	Tribes (15)		Communities (3)
Navajo Nation	Cocopah	Pascua Yaqui	Ak-Chin
Ft. McDowell-Yavapai Nation	CRIT	Quechan	Gila River
Tohono O'odham Nation	FMIT	San Carlos Apache	SRPMC
Yavapai-Apache Nation	Havasupai	Tonto Apache Payson	
	Hopi	White-Mountain Apache	
	Hualapai	Yavapai-Prescott	
	Kaibab-Paiute	Southern San Juan Paiute	
	Pueblo of Zuni		



With respect to the tribal healthcare structure, Arizona tribes are provided healthcare services through IHS and PL 93-638 programs. There are 9 hospitals that are Title III, Title V, or IHS facilities. There are 51 ambulatory clinics that provide services from Title III, Title V or IHS facilities or tribal developed facilities. Based on tribal presence and the need for quality healthcare programs, healthcare systems have also implemented a government-to-government consultation process including ADHS and CDC.

Regarding tribal PHEP programs, based on the consultation policy, the ADHS reaches out to 21 tribes, with 15 signed onto the PHEP program and 3 in the introductory process. Arizona tribal PHEP funds are based on a distribution formula, with a \$50,000 base amount and a population-based calculation of tribal members residing on reservations based on the 2000 Census count. Tribes and counties have specific deliverables and IGA contracts. A Tribal Collaborative Team of 5 representatives was introduced in 2006, which serves as an Executive Body to address a unified approach to emergency events (e.g., Strategic Plan). ADHS provides a Tribal Preparedness Coordinator who assists tribes with daily PHEP operations issues and questions, visits tribal programs, and coordinates meetings. CDC provides PHEP cooperative agreement funding to 62 grantees, which include 50 states, 8 territories (Puerto Rico, the Virgin Islands, American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Republic of the Marshall Islands, Republic of Palau, and the Federated States of Micronesia), and 4 metropolitan areas (Washington, DC, Chicago, Los Angeles County and New York City).

Ms. Granillo explained that the Arizona Tribal PHEP Collaborative Team has developed a Strategic Plan as a unified tribal PHEP plan to address tribal health issues by preparing for and responding to tribal people’s needs to improve the health of tribal people on their lands with a mission and vision statement, identified core values and guiding principles and established focus areas. The basic aim of strategic planning is to actively determine the nature or character of the organization and to guide its direction. It identifies the mission and mandates of the organization and devises strategies for fulfilling its purposes:



In July 2009, The Arizona Center for Public Health Preparedness (AzCPHP) was asked to facilitate first session. They began with a basic SWOT Analysis (strengths, weaknesses, opportunities, and threats) to formulate the mission, vision and goals. The process was very rudimentary in the beginning, but became much more expansive as time passed. Tribes had a more vested interest of the benefits and value to having a strategic plan as new BP begins in



2010. They met monthly through December 2009, adding supporting evidence to support each goal and objectives pertaining to other programs in place that can work under this model. Though PHEP has been allocating funding since 2003, this is a strategy that had never been implemented. Though it seemed as though they were taking a lot of steps backwards, a new guidance will be issued in August 2010, so the timing was perfect to start with a strategic plan. The plan is for fiscal years 2010 through 2013. The strategic plan is a framework for decision making, it sets out a vision for how to move forward, and is a stimulus for change. In general, the Arizona tribes do have a good relationship with ADHS; however, there are still some challenges and there is still some resistance amongst the leadership within ADHS. On January 15, 2010, the plan was presented to the ADHS Interim Director, Mr. Will Humble, who fully endorsed the plan. Garnering that support was key, so this was a major accomplishment.

The strategic plan components include the following:

- Mission Statement
- Vision Statement
- Core Values and Guiding Principles
- Focus Areas
- Goals (6) and Strategies
- Objectives
- Key Performance Indicators
- Supporting Research and Evidence
- Appendices (Supporting Tribal Consultation Policy)

As noted, use of the new guidance will begin in August 2010. One of the key strategies in this plan was to be able to identify new initiatives to enhance existing tribal PHEP program. In the past, if funding was not spent it would be returned to the state health department where it was spent on other programs. The idea was to include a goal or strategy regarding how to reallocate those dollars for the tribal PHEP program. One of the first initiatives proposed was to developed a tribal needs assessment, which was scheduled to begin in February. Arizona participated as one of the state models for Project Public Health Ready (PPHR), which is funded through National Association of County and City Health Officials (NACCHO). However, because the tribes are not counties and do not fit within that model, they were not part of the assessment. However, Ms. Granillo's argument was that tribes should have been part of the assessment because it would have offered a better picture of the state of preparedness for that state. Of the 15 counties in the state, 14 participated in PPHR, but there was no tribal input at all. The tribal needs assessment will help to identify gaps in training, personnel, resources, and infrastructure and greatest threats to the tribes and will be competency and capability-based. The next step will be to establish a formal Arizona Association of Tribal Public Health Emergency Preparedness Coordinator's (AAT-PHEPC) and executive body, and to implement the plan.

Mr. Johnson then discussed the mission and vision statements and the goals and objectives of the strategic plan.

The mission statement is as follows:

The Arizona Tribal Public Health Emergency Preparedness Programs, in coordination with the Centers for Disease Control and Prevention and the Arizona Department of Health Services, serves as the focus for tribal health issues by preparing for and



responding to our people's needs through tribal leadership and an integrated all-hazards approach to improve the health of tribal people on their lands.

The vision statement is as follows:

It is through listening and learning we can *understand* what to recommend what is best for the people. As a liaison body we will *listen* to the drum beat and heart beat of the people's needs, as well as the latest medical technology to *learn* what is best for our people. It is our vision to listen, to learn, to understand, to respect, to acknowledge, and only then can we act *wisely* to create an effective emergency preparedness program for the health of our "People."

The strategic plan goals are presented and are to be understood as follows:

- Only Goal 1 is determined as a long-term goal, wherein as in other agency programs, tribes may attain the status of "treatment as a state" and based on eligibility requirements, have direct funding from the CDC
- Goals 2 through 6 address the consultation process between the state and tribes under the cooperative agreement to improve in determining programs that have a direct impact to tribal healthcare needs.

#### Goal 1 & Strategy

- Goal 1:** To foster government -to-government relationships to enhance tribal preparedness.
- Strategy 1:** *To improve the relationship with the CDC to promote advocacy and support for tribal goals, objectives, and new initiatives.*

**Objective 1.1:** To develop a process that facilitates inquiry for direct funding from the CDC.

**Objective 1.2:** To increase inter-tribal communications.

**Objective 1.3:** To increase the multi-jurisdictional coordination across and between neighboring agencies.

**Objective 1.4:** Recognition of some tribes' capacity to sustain PHEP activities for treatment as a county (TAC) and treatment as a state (TAS)

#### Supporting Evidence

- EPA has "treatment-as-state" TAS programs. Several Arizona tribes have met eligibility requirements and have a direct TAS relationship with EPA
- IHS has the "self-governance" program through PL 93-6318 Title 3 and Title 5 programs where tribes meeting eligibility requirements manage their healthcare separate from IHS intervention
- State Homeland Security Program (SHSP) provides supplemental funding directly to eligible tribes to strengthen tribal governments to associated risks

Each of these support examples have common elements that were implemented in becoming direct government-to-government relationship programs. An agency consultation process brought about the government-to-government programs. Each program was enacted by a Congressional act. Each program establishes eligibility requirements. Tribes have met requirements and enjoy a direct government-to-government relationship.





### Goal 2 & Strategy

- ❑ **Goal 2:** To create effective community awareness, preparedness, training and education programs for the health of native people.
- ❑ **Strategy 2:** *To evaluate existing infrastructure to identify gaps to improve agency capacity to plan, detect, respond, recover, and mitigate public health emergencies.*

**Objective 2.1:** To align the tribal PHEP program to the 9 CDC Preparedness Goals.

**Objective 2.2:** To build community awareness through educational and outreach programs for native members.

**Objective 2.3:** To collaborate with respective agencies in community awareness programs for native members off-reservation.

**Objective 2.4:** To develop operational capabilities to respond to public health threats by developing tribal use of the Navajo and the Inter Tribal Council of Arizona (ITCA) Epi Center's, which must be supported by additional funding sources and inter-tribal agreements (ITA's).

**Objective 2.5:** To enhance the communities we serve through surveillance and mitigation activities.

**Objective 2.6:** To ensure resources are available and allocated for effective community response

**Objective 2.7:** To increase trained emergency preparedness personnel in community outreach and awareness programs.

### Goal 3 & Strategy

- ❑ **Goal 3:** To establish a process to review and have input into the requirements of Public Health Emergency Preparedness Cooperative Agreement(s).
- ❑ **Strategy 3:** *To meet with appropriate agency officials to discuss and review cooperative agreement requirements, limitations, expectations and explanation of the conditions of appropriations within a timeframe that allows for efficient planning.*

**Objective 3.1:** To identify and establish a process that allows tribes an effective review of budgets, which includes active participation by the Tribal PHEP Collaborative team with appropriate agency officials during the initial planning period of the Cooperative Agreement.

**Objective 3.2:** To actively participate and have tribal collaborative team representation in state grantee awardees meetings to facilitate transparent communications regarding the cooperative agreements.

**Objective 3.3:** To establish a process that identifies new tribal initiatives with unspent funds in alignment with cooperative agreements.

**Objective 3.4:** To establish a vetting process that aligns deliverables and budget with tribal priorities.



### Goal 4 & Strategy

- ❑ **Goal 4:** To enhance the integrated all-hazards approach to public health emergency preparedness.
- ❑ **Strategy 4:** *To adopt the National Incident Management System (NIMS), the National Response Framework (NRF) and other standardized policies, procedures and training to enhance All-Hazards Public Health Preparedness and Response within Tribal Communities.*

**Objective 4.1:** For Public Health Preparedness and Public Health Incident Command Tribal Staff to meet a minimum level of NIMS compliance consisting of ICS 100, 200, 300, 700, 800 & 808

**Objective 4.2:** To incorporate National standardized guidance and compliance standards within Tribal Public Health Preparedness plans, policies, procedures and exercises.

**Objective 4.3:** To develop All-Hazards Public Health Preparedness Plans for each Tribal Community.

**Objective 4.4:** To increase workforce development by attending trainings, conferences and workshops to build and foster tribal knowledge and experience in an all-hazard, integrated approach to Public Health Preparedness and Response.

**Objective 4.5:** Develop a coordination and integration strategy to work with other responder disciplines in an all-hazards emergency.

**Objective 4.6:** To participate in activities that support the framework of the NACCHO Project Public Health Ready Recognition Program (PPHR), this would need to be adapted to meet the needs of the tribes thus requiring funds (i.e. carry-over or set-aside funds).

### Goal 5 & Strategy

- ❑ **Goal 5:** To enhance the recognition of the Tribal Collaborative Team as the executive body for Arizona Tribal Public Health Emergency Preparedness Coordinator's.
- ❑ **Strategy 5:** *Formalize the development of an Arizona Association of Tribal Public Health Emergency Preparedness Coordinator's (AAT-PHEPC), which would facilitate the development of an executive committee that serves as the liaison to all PHEP coordinators.*

**Objective 5.1:** To draft a set of By-Laws that provides a foundation for the establishment of AAT-PHERC.

**Objective 5.2:** To provide for a systematic review of the proposed By-Laws within six months of the initial draft.

**Objective 5.3:** The proposed By-Laws may include the provision of sub-committees to carry out the work and advocate on behalf of the Association.

**Objective 5.4:** The proposed By-Laws may also include the establishment of a Tribal Collaborative Team to represent the Association in meetings with the State of Arizona, County Associations, federal agencies and other entities as may be determined by the Association.



### Goal 6 & Strategy

- ❑ **Goal 6:** To identify alternative funding and contracting mechanisms for tribes to participate in Public Health Emergency Preparedness Activities to include ADHS PHEP contracting program.
- ❑ **Strategy 6:** *To establish a process or system for identifying funding sources and opportunities.*

**Objective 6.1:** Utilize the Inter Tribal Council of Arizona (ADHS contracts with ITCA) to identify alternative funding and contracting mechanisms, sources and procedural requirements for Tribal Public Health Emergency Preparedness.

The Arizona tribal populations range from 162 members to over 200,000 members. This goal addresses the needs of small tribes to join county partners as “jurisdictional partners” taking the lead and the small tribe having quality Public Health Emergency Preparedness program filling the people’s needs.

Ms. Granillo reported that there have been numerous benefits to the strategic planning process. Arizona governments, either the state or tribal governments, have exhibited strong leadership in the arena of the consultation process. GOAL 1 has the vision of one day for successful tribes in the PHEP program to have a “treatment as a state” consultation status with the CDC and have direct funding as demonstrated in other agencies. This is the only long-term goal as noted. GOAL 3’s intent is to insure that tribes have a voice at the “consultation table” when the cooperative agreement is finalized at the state awardee-to-tribal government level when decisions are made. GOAL 5 establishes a tribal executive body that is representative to the state for all of the Tribal PHEP programs when the need arises. GOALS 2, 4, and 6 address improving the consultation process in the cooperative agreement scope of work.

The Arizona Association of Tribal Public Health Emergency Preparedness Coordinator’s would be established as a formal association modeled after the Arizona Local Health Officer’s Association (ALHOA), the Tribal Collaborative Team will serve as the executive body for the Tribal Public Health Emergency Coordinators. Through the Arizona Association of Tribal Public Health Emergency Preparedness Coordinator’s Association there would be an executive body for advancing the government-to-government consultation process.

There were also challenges, such as 21 tribes coming together in a unified PHEP approach. There have been monthly meetings since July 2009 to finalize the plan. Receiving endorsement and support from the ADHS Interim Director was a challenge, but has been accomplished. With respect to implementation of the plan, the challenges include limited resources, limited personnel, maintaining continuous buy-in and support, et cetera. The Tribal Strategic Plan will prove to be a valuable consultation tool as we in Arizona tribally unified meet the challenges of the Public Health Preparedness Program initiatives.



The next steps are to receive endorsement from the AHDS, which has been done; share the report with CDC TCAC, which has been done; receive support from CDC on initiatives and TAS for some tribes; receive input from other tribal PHEP programs across the country; implement the plan; and evaluate and monitor the plan (including maintaining and updating the plan). The Arizona Tribal Strategic plan is a “living document” and will continually be updated to meet the challenges of bioterrorism or disease outbreak.

Ms. Granillo concluded that one of the initiatives they would also like to move forward on pertains to how to use Tribal Epidemiology Centers more effectively. She also shared the website address for the strategic plan, and contact information for herself and Mr. Johnson.

The strategic plan website is as follows:

<http://www.azdhs.gov/phs/tribal/TribalPreparedness.htm>

Contact information is as follows:

Brenda Granillo, MS, Director  
Arizona Center for Public Health Preparedness  
bgranill@email.arizona.edu  
(520) 626-0617

Luke Johnson  
Tribal PHEP Coordinator  
Ft. Mohave Indian Tribe  
lukejohnson@fortmojave.com  
(760) 326-9650

### **Discussion Points**

- Mr. Johnson stressed the importance of reading every word of every cooperative agreement to clearly understand what is being agreed to.
- Ms. Hughes said that she personally was not aware of a strategic plan in the Bemidji Area, although she knew that in Wisconsin there were agreements. However, it was not clear to her whether all 11 Wisconsin tribes have the same relationship with the State of Wisconsin. They do have the collaborative letter from each of the tribes in Wisconsin. They also had the opportunity to test the plan with H1N1. In distributing the vaccines, they actually referred to the preparedness plan to establish clinics and working relationships with the tribes and counties. They also had a significant snow storm that affected several areas across the Midwest, particularly the smaller communities and the reservation, which presented another opportunity to test the plan. Though unfortunate, each event does offer the opportunity to test and improve the plan. She said she would inquire as to whether they had a formal strategic plan.

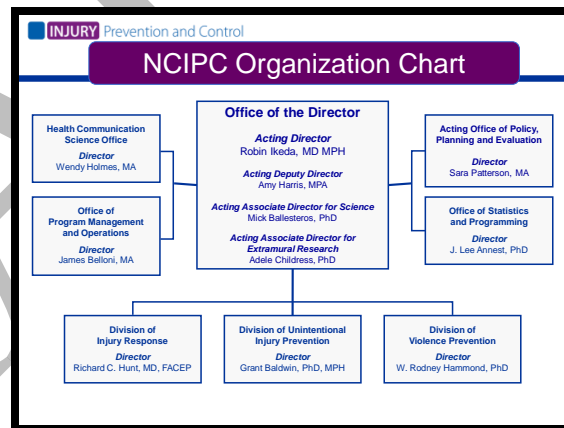
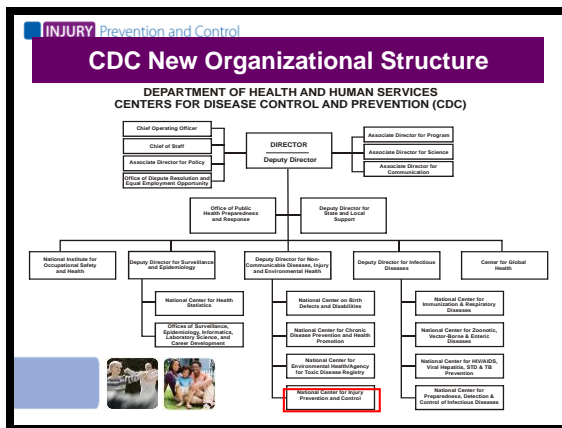


# National Center for Injury Prevention and Control (NCIPC)

## Overview

**Mick Ballesteros, PhD, Acting Associate Director for Science  
National Center for Injury Prevention and Control (NCIPC)  
Centers for Disease Control and Prevention (CDC)**

Dr. Ballesteros indicated that NCIPC’s mission is: “To prevent injuries and violence and reduce their consequences so that people can live to their full potential.” CDC began studying home and recreational injuries in the early 1970s, violence prevention in 1980, and was established as a CDC Center in 1992. Within the large agency of CDC, organizationally NCIPC sits within the Deputy Director of Non-Communicable Diseases, Injury, and Environmental Health. The other national centers grouped with NCIPC include: National Center for Birth Defects and Developmental Disabilities (NCBDDD), Nation Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), and National Center for Environmental Health (NCEH) / Agency for Toxic Substances and Disease Registry (ATSDR). CDC’s new organizational structure and NCIPC’s organization structure are as follows:



NCIPC is one of the smallest centers within CDC, encompassing only about 1.5% of CDC’s total budget and having a staff of about 130 people. Dr. Robin Ideka is NCIPC’s Acting Director. There are several key offices, including those focused on communications, policy, extramural research, and statistics and programming. The primary organizational units of the center, where the “on-the-ground” work occurs are the three divisions: Division of Injury Response (DIR), Division of Unintentional Injury Prevention (DUIP), and Division of Violence Prevention (DVP).

NCIPC recognizes that injuries occur despite all of the efforts made in prevention, so DIR works to improve injury care and response practices. Their goal is primarily secondary and tertiary prevention (e.g., once an injury has occurred, minimizing injury severity and long-term consequences). These consequences can be extensive and wide-ranging. Injuries have physical, emotional, and financial consequences that can impact the lives of individuals, families, and society. Some injuries can result in temporary and long-term disabilities. DIR is divided into two teams: Research Team and Program Team. The priority topic areas include: Acute Injury Care, Alcohol Screening, Field Triage, Blast and Explosion Injuries, Mass Casualties, and Advanced Automatic Collision Notification. DIR also runs the Core State Injury



Program, which is a 30-state grant program through which CDC provides state health departments the resources and training needed to build a solid infrastructure for injury prevention and control. This allows the state grantees to collect, analyze, and use injury data and to implement and evaluate interventions. Much of the programmatic work that NCIPC does as a center flows through the Core State Injury Programs.

Unintentional injuries, homicide, and suicide, are the leading cause of death for people 1 to 44 years of age. DUIP is mainly concerned with primary prevention, and has two teams: Home and Recreation Team and Motor Vehicle Team. The Home and Recreation Team addresses issues concerning: Falls, Residential Fires, Drowning, Poisoning, and Sports. The Motor Vehicle Team addresses issue pertaining to: Drivers, Occupants, Motorcyclists, Pedestrians, Bicyclists, Teen Driving / Graduated Drivers Licenses (GDL), and Alcohol Impaired Driving. These injuries can occur in a variety of settings, including schools, homes, roads, playgrounds, recreational sites, public parks, and community. The setting affects the risks and prevention strategies. Work-related injuries are actually the purview of the National Institute of Occupational Safety and Health (NIOSH), which is another institute within CDC, so in general, NCIPC does not deal with work-related injuries. In general, death rates from unintentional injuries have been either stable or increasing. However, there are three areas with increasing rates of death, including falls among older adults, drug overdose and poisonings, and deaths among motorcyclists. Thus, DUIP is working diligently to better understanding why these increases are occurring and what can be done to address them.

Violence is also a serious public health problem in the US. From infants to the elderly, it affects people in all stages of life. In 2006, more than 18,000 people were victims of homicide and more than 33,000 took their own lives. The number of violent deaths tells only part of the story. Many more survive violence and are left with permanent physical and emotional scars. Violence also erodes communities by reducing productivity, decreasing property values, and disrupting social services. DVP is committed to stopping violence before it begins. This is the largest division within NCIPC. There are three branches: Etiology and Surveillance, Prevention Development and Evaluation, and Program Implementation and Dissemination. The priority areas for violence prevention include: Intimate Partner Violence, Sexual Violence, Child Maltreatment, Youth Violence, and Suicide. Emerging areas include: Global Violence Prevention and Elder Abuse.

All three of the divisions within NCIPC work across the public health model to conduct surveillance, conduct foundational intervention and dissemination research, and implement and evaluate programs. NCIPC has three priority areas of focus: Child Maltreatment Prevention, Older Adult Fall Prevention, and Motor Vehicle Injury Prevention. These are priorities because of their high costs, the availability of solutions to address the issues, and the severity of the related injuries and their consequences. In these areas, NCIPC is making an extra effort to show some national leadership in pushing research and dissemination of prevention strategies. Injury is a significant public health problem. In 2006 in the US, there were 179,000 injury-related deaths and more than 3 million individuals were treated for injuries in emergency departments. Injuries are not accidents, unpredictable, random, or uncontrollable acts of fate. The steps of the public health model can be used to understand the magnitude of the problem; identify risk and protective factors; and develop, test, evaluate, communicate, and implement prevention strategies and policies. Injuries are understandable, predictable, and preventable.

NCIPC has worked with local public health agencies by providing technical assistance on data, study design, program development, et cetera. NCIPC has subject matter experts (SMEs) for



most areas of injury and violence. At the request of local communities, NCIPC can conduct EpiAid investigations on discrete public health issues. NCIPC also allocates funds through grants, cooperative agreements, and contracts on a competitive basis to address specific research questions or develop specific programs or products. In 2009, NCIPC released the second version of its injury research agenda. This document, titled *CDC Injury Research Agenda*, describes the scope of research needs and priorities in injury and violence for 2009 through 2018. Revising the first version of the research agenda allowed NCIPC the opportunity to review research accomplishments and progress toward NCIPC's goals. The agenda is organized by topics that essentially track the divisions, and includes a section on research priorities for cross-cutting topic areas. The document can be viewed in its entirety at the following address: <http://cdc.gov/injury/researchagenda>

NCIPC also has an injury data query system called the Web-Based Injury Statistics and Reporting System (WISQARS™). This is an interactive database system that provides customized reports on injury-related data. It is a very user-friendly site of which one can download US and leading causes of death and injury, and obtain the most recent statistics for fatal and non-fatal injuries. Additionally, data were recently added from the National Violent Death Reporting System (NVDRS). Depending upon which database is being used, queries can be run on injury intent, mechanism, year, race, and state. In 2010 and 2011, additional modules will be added to WISQARS™, one of which is a mapping function that will allow for the creation of national, state, and county level maps for injury mortality rates; and the other is a cost module that will permit the estimation of direct medical costs for injury mechanisms for specific populations.

The following additional resources are also available from NCIPC:

- ❑ Injury Surveillance Training Manual  
<http://www.cdc.gov/ncipc/dvp/InjSurveillance/InjurySurveillance.htm>

This manual was developed to be used in international settings in low-income countries. It addresses the basic concepts of surveillance, data sources, coalitions, methodology, development of an analysis plan, and how to use injury surveillance data to inform prevention programs. This is a very good resource to assist in thinking about capabilities and needs in communities.

- ❑ The History of Violence as Public Health Issue  
<http://www.cdc.gov/violenceprevention/pub/historyofviolence.html>

This document, published in 2009, describes when and how violence was recognized as a national and global issue. This is a very nice review of the timeline of the last 30 years, including seminal event and reports on violence as it became recognized as a public health issue.

- ❑ Protect the Ones You Love  
<http://www.cdc.gov/SafeChild/about.htm>

This is a CDC initiative to raise parents' awareness about the leading causes of child injury in the US and how they can be prevented. This site includes a number of resources to help parents keep their children safe from injuries (e.g., fact sheets, podcasts, media outreach



guides, et cetera). There are specific materials pertaining to drowning, burns, falls, poisoning, and road traffic injuries.

- ❑ Demonstrating Your Program's Worth (Evaluation)  
<http://www.cdc.gov/ncipc/pub-res/demonstr.htm>

This is a short book that shows how to demonstrate the value of programmatic work to the public, peers, funding agencies, and people served. This book explains how to conduct a simple evaluation, how to use evaluation to improve programs, and how to incorporate evaluation into the activities of an intervention program itself.

- ❑ Injury Framing Guide  
<http://www.cdc.gov/injury/CDCFramingGuide-a.pdf>

This is a communication tool for talking about injury. This guide incorporates framing theories, message development techniques, and vehicles for explaining important public health statistics. The information and tools provided in this guide can be used to build messages that can be included in press releases, speeches, annual reports, and research articles to help professionals better communicate with their audiences.

- ❑ Injury Center Publications and Resources  
<http://www.cdc.gov/injury/publications/index.html>

This link includes all of the resources available from NCIPC.

In closing, Dr. Ballesteros shared his contact information, which is as follows:

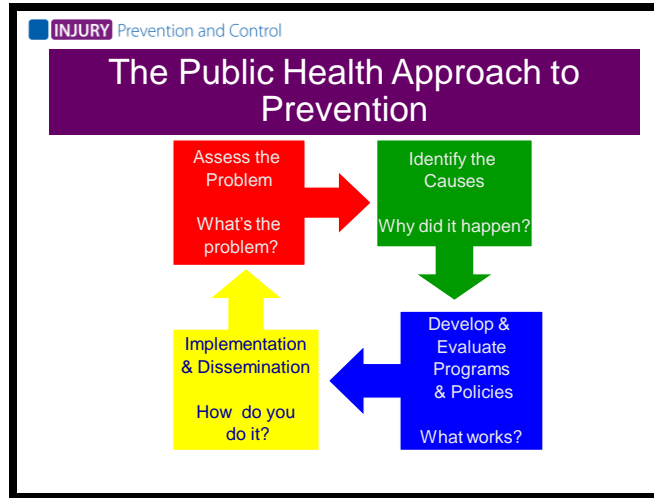
Mick Ballesteros, PhD  
Work Number: 770-488-1308  
Fax Number: 770-488-1317  
Email: [mballesteros@cdc.gov](mailto:mballesteros@cdc.gov)

### **Division of Violence Prevention**

**Alex Crosby, MD, Epidemiologist**  
**Division of Violence Prevention (DVP)**  
**National Center for Injury Prevention and Control (NCIPC)**  
**Centers for Disease Control and Prevention (CDC)**

Dr. Crosby pointed out that CDC has a strong tradition of partnering with other agencies, like the Department of Justice (DOJ), to make a measurable impact on the health and well being of Americans. As noted, the mission of DVP is to prevent injuries and death caused by violence. This mission is accomplished mission in four steps, following the public health approach to prevention as shown in the following model:





First, DVP assesses the problem using sound science and epidemiology. Next, they identify the causes of violence that need to be addressed in prevention programs and policies. Then, they evaluate interventions and policies to determine which approaches are working. Finally, they encourage widespread adoption of programs and policies based on scientific evidence. The public health approach is very dynamic in that each stage is intended to provide the knowledge and information to inform the next step. The public health approach is basically a way to systematically examine any health problem or disease. This applies across the range of various diseases that CDC or any public health agency may address. It is a very logical approach and a very effective one.

With respect to the magnitude of the problem, Dr. Crosby shared the following tables which reflect the leading causes of death by ethnicity in the US in 2006, and the leading causes of death among AI / AN by selected ages in the US in 2006. 2006 is the most recent year for which there are full national data:

Leading causes of death by ethnicity – United States, 2006					
Rank	White	Black	American Indian/AN	Asian	Latino
1	Heart Disease	Heart Disease	Heart Disease	Malignant Neoplasms	Heart Disease
2	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms	Heart Disease	Malignant Neoplasms
3	Chronic Low Respiratory	Cerebro Vascular	Unintentional Injuries	Cerebro vascular	Unintentional Injuries
4	Cerebro vascular	Unintentional Injuries	Diabetes Mellitus	Unintentional Injuries	Cerebro vascular
5	Unintentional Injuries	Diabetes Mellitus	Liver Disease	Diabetes Mellitus	Diabetes Mellitus
6	Alzheimer's Disease	Homicide	Cerebro Vascular	Influenza and pneumonia	Liver Disease
7	Diabetes Mellitus	Nephritis	Chronic Low Respiratory	Chronic Low Respiratory	Homicide
8	Influenza and pneumonia	Chronic Low Respiratory	Suicide	Nephritis	Chronic Low Respiratory

Source: CDC Vital Statistics

Leading causes of death among AI/AN, Selected Ages, US, 2006					
Rank	10-19 years	20-29 years	30-39 years	40-49 years	50-59 years
1	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Malignant Neoplasms
2	Suicide	Suicide	Suicide	Heart Disease	Heart Disease
3	Homicide	Homicide	Heart Disease	Liver Disease	Unintentional Injuries
4	Congenital anomalies	Heart Disease	Liver Disease	Malignant Neoplasms	Liver Disease
5	Malignant Neoplasms	Malignant Neoplasms	Homicide	Suicide	Diabetes Mellitus

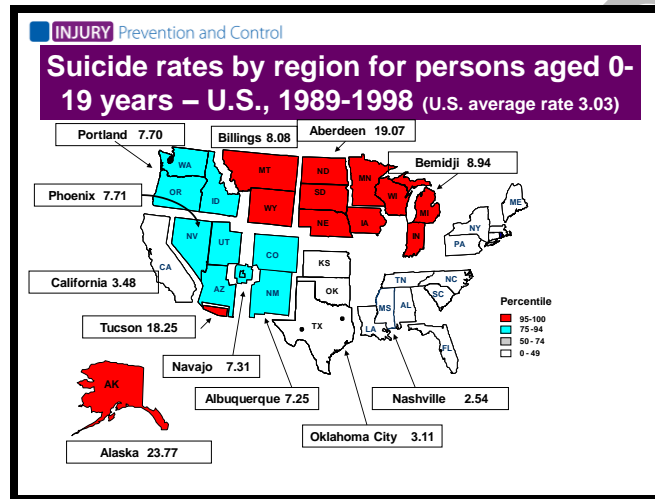
Source: CDC vital statistics

As reflected in the tables, homicide and suicide rank in the top 8 for several populations. Among AI / AN, suicide ranks as the 8<sup>th</sup> leading cause of death; however, this is not the whole story. When assess by selected ages, suicide disproportionately affects young people. It is the second leading cause of death among those 10-19, 20-29, and 30-39 years of age. Suicide is the 5<sup>th</sup> leading cause of death in those 40-49 years of age. Based on the 5 major racial and ethnic groups, there is a distinct pattern among several groups in terms of where suicide rates



are the highest, with the rates highest especially among AI / AN adolescents and young adults, after which the rates begin to drop. While not the same magnitude, that pattern is very similar among African Americans, particularly among males. Understanding where the different patterns are helps to focus prevention programs.

The suicide picture is also very different looking across some of the regions and different tribes, from very high rates in the Aberdeen Area and Alaska to very low rates in Nashville. Where suicide is a problem cannot be cast with a broad brush. The following map reflects this by IH S regions:



Looking across the public health approach, selected CDC activities in violence prevention among Native Americans fall in some of the following areas:

- ❑ Problem Description / Surveillance
  - National Violent Death Reporting System
  - Sexual violence assessment among minority women, including AI / AN
- ❑ Program evaluation
  - Enhanced evaluation of tribal youth suicide prevention program (G. L. Smith Memorial Act with Substance Abuse and Mental Health Services Administration, which funds 17 tribes); DVP entered into an agreement, along with SAMHSA, to conduct a more focused evaluation of a particular project in the Portland Area: The Native American Rehabilitation Association that works with 8 federally recognized tribes in Oregon.
- ❑ Multiple activities with
  - Tribal Epidemiology Centers
  - Health disparities in adolescent suicidal behavior

NVDRS began in 2002 and currently operates in 18 states: Alaska, Colorado, Georgia, Kentucky, Massachusetts, Maryland, Michigan, North Carolina, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin. One of the benefits of this system is that it allows communities to examine information on violent deaths (e.g., homicides, suicides, firearm injuries, undetermined deaths) in more detail than a death



certificate. This system links data from police, coroner, medical examiner, crime lab, and death certificates. NVDRS includes demographic and other information about the decedent (e.g., age, sex, race, marital status, employment status, occupation, veteran status, pregnancy status, etc. Information about suicide event); place, date and time of injury, and method used; circumstances of suicide (e.g., mental health and treatment; intent [note, stated intent, attempts], and precipitating circumstances).

DVP will soon undertake the prevalence of sexual violence assessment. The purpose of this effort is to assess the characteristics, circumstances, and help-seeking behavior related to sexual violence among African American, Hispanic, and AI / AN women. Some older surveys, though decades old, suggest that these three populations are probably at higher risk than the majority population. This is a pilot project to determine the feasibility of paper-and-pencil, face-to-face interviews in collecting sexual violence-related data. AI / AN data collection is proposed to occur in Seattle.

With respect to the enhanced evaluation of the Garrett Lee Smith funded suicide prevention, SAMHSA initially funded 13 states and 1 tribe with funds from the Garrett Lee Smith Memorial Act. CDC is funding 3 of these sites to conduct an enhanced evaluation. One of the 3 conducting enhanced evaluation is the Native American Rehabilitation Association (NARA) of Oregon. The NARA program will be evaluated to determine whether it utilizes culturally appropriate strategies and community mobilization, and addresses reservation-based Native American youth. They are working with 8 federally recognized tribes in Oregon, and strategies are being built by the tribes themselves. They have developed their own adolescent health behavior survey to examine risk and protective factors, and have been willing to share this information with other tribes who are trying to engage these types of assessments.

In terms of collaboration with the Tribal Epidemiology Centers, these are small groups of scientists, mainly epidemiologists, located around the US. They provide technical assistance to the tribal governments on health studies. Routine conference calls are convened with the Tribal Epidemiology Centers, CDC, and IHS to discuss injury-related subjects, including suicidal behavior.

DVP convened a Health Disparities Meeting in September 2009. This meeting was a collaboration between CDC, IHS, and SAMHSA. The meeting was convened to address adolescent suicide among American Indian / Alaska Native and Hispanic / Latino youth aged 10-24 years to try to develop recommendations to improve / support comprehensive prevention efforts for suicidal behavior among those populations. DVP is in the process of revising those recommendations to be much more strategic and specific, along the lines of the public health approach, for those populations.

### **Evidence-Based Programs Implemented in Tribal Communities**

**CDR Holly Billie, Senior Injury Prevention Specialist  
National Center for Injury Prevention and Control (NCIPC)  
Centers for Disease Control and Prevention (CDC)**

CDR Billie briefly described the motor vehicle evidence-based programs that were implemented in four tribal communities: San Carlos Apache (SCA), Tohono O'odham Nation (TON), White Mountain Apache Tribe (WMA), and Ho-Chunk Nation (HCN). Basically, known effective



strategies for reducing motor vehicle-related injuries were tailored and implemented in these 4 tribal communities. Motor vehicle-related injuries are a major problem among American Indians / Alaskan Natives. Motor vehicles crashes are the leading cause of death overall for Native Americans aged 1 to 44, and the 4<sup>th</sup> leading cause of death for all ages. On average, two AI / AN are killed every day in crashes in the US, which is the reason NCIPC decided to focus some of their motor vehicle efforts in tribal communities.

Starting in the fall of 2004, the CDC injury Center awarded approximately \$72,000 to each of these four tribes to design, implement, and evaluate effective injury prevention programs to reduce motor-vehicle related injuries and deaths among members of their own communities. Over the course of their 5-year grants, staff implemented interventions selected from *The Guide to Community Preventive Services*, a systematic review of community-based interventions. This initiative began as a 4-year grant, but a fifth year was added. The tribes selected at least two effective strategies to increase restraint use, including seatbelts and car seats, and to address driving while intoxicated (DUI). The tribes hired a coordinator to work with local police departments and others in their communities to increase seatbelt and car seat use, and to reduce DUI. The two following tables reflect the focus areas of each program, and the results:

**INJURY Prevention and Control**

**Program Focus**

Tribes	Increasing Seatbelt Use	Increasing CSS Use	Reducing DUIs
SCA	✓	✓	✓
TON	✓	✓	✓
WMA	✓	✓	✓
HCN	✓	✓	✓

✓ Strong Focus      ✓ Some Focus

**INJURY Prevention and Control**

**Results**

Tribes	Increasing Seatbelt Use	Increasing CSS Use	Reducing DUIs
SCA	Up 46% Passed law		Arrests up 52% Passed .08 BAC
TON	From 43% to 74.5%		Passed .08 BAC
WMA	From 13% to 54%		24 checkpoints
HCN	Up 38%	From 26% to 76%	

Although these are simple illustrations, considerable work went into implementing these programs by the tribes. The interventions included major media campaigns, car seat education and distribution, working to pass new laws in the communities, conducting enforcement checkpoints, et cetera. As reflected in the second table, all four tribes experienced pretty remarkable results. All four tribes were successful in increasing seat belt use, one tribe increased car seat use, and two tribes were successful in passing stronger laws. These were major improvements in the communities in terms of addressing motor vehicle crashes.

It is important to note that sustainability is always an issue. If there is a good program in a community, it is important to keep it there as long as possible. This is difficult to do when funding runs out; however, all four of these tribes had some level of sustainability after their funding ending in the past fall. For example, the San Carlos Police Department decided to continue funding their program. Tohono O’odham Nation will continue data collection and some media as they search for new funding. White Mountain Apache Police Department has decided to hire a coordinator to continue some of their activities. Early on, the Ho-Chunk Nation reported their successes to their Tribal Council, which incorporated the entire program into the tribal budget. Successes of these tribes are currently highlighted on the CDC injury webpage at: <http://www.cdc.gov/Motorvehiclesafety/native/research.html> CDR Billie indicated that she



would also share written materials and posters that the tribes developed when they presented their successes during a major highway safety conference that is convened on an annual basis.

With respect to next steps, the University of North Carolina (UNC) Injury Prevention Center helped several of the funded tribes with evaluation. UNC will be providing a final evaluation report that will include statistical results and challenges and barriers the tribes experienced in implementing their programs. This report will assist in CDC's plans to develop a manual that all tribes can use to implement strategies to reduce motor vehicle injuries in their own communities. The motor vehicle program continues to seek ways to work with tribes in the area of motor vehicle injury prevention, because this is an important focus of DUIP.

DRAFT



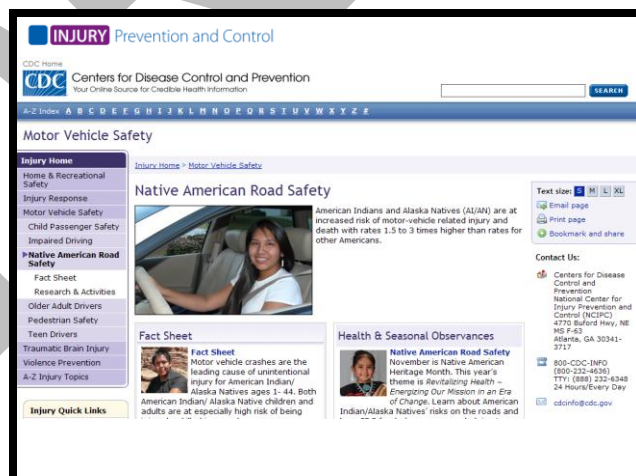
CDR Billie also reported on a new initiative that began in the fall of 2009 to more closely examine AI / AN elder fall prevention. She and Dr. Judy Stevens, CDC Elder Fall Expert, are involved from NCIPC. This year's objectives are to:

- ❑ Develop a data monograph reflecting key information about fall-injury in the elderly, including AI / AN-specific data, general population data that provides perspective on AI / AN population.
- ❑ Identify interventions with strong evidence for reducing fall-injury in the elderly, clustered thematically as: Clinical, Public Health, and Community-Based
- ❑ Develop an inventory of current efforts in Indian Country, including public health injury prevention, clinical fall risk assessment and intervention, tribal home modification programs, and AoA Title VI (Senior Center)-based programs.

There are some prevention materials that are native-specific. For example, the National Fire Protection Association (NFPA) has a native-specific program called *Remembering When*™ for which they use all native photographs. NCIPC uses this resource frequently when working with tribes. The URL is as follows:

<http://www.nfpa.org/categoryList.asp?categoryID=203&URL=Safety%20Information/For%20public%20educators/Education%20programs/Remembering%20When>

CDC is also involved in an effort to collaborate with other agencies charged with addressing Native American highway safety including IHS, BIA, and NHTSA. During the last CDC TCAC meeting held in Anchorage in August 2009, Tribal Leaders wondered why there was not much Native American-specific information on CDC's web pages. In response, NCIPC's Motor Vehicle Team worked to post the tribal motor vehicle successes and also the following general Native American Road Safety page:





## **Discussion Points**

- Mr. Franklin indicated that last year, his grandfather died from a fall. He was 81 years old and Mr. Franklin was on the road working; whereas, usually he is home. He went to college to become a paramedic and his family would look to him for those types of questions when his grandfather fell. Unfortunately, he did not receive the phone call until four days later. By that time, so much blood had accumulated on his brain, he had a stroke, went into a coma, and passed soon after that. Mr. Franklin always thought it could have made a difference if there were posters in their clinic or some type of outreach indicating what to do for an elder who falls. He knew that after a certain age, someone should be taken in after a fall just in case. His grandfather is stubborn and felt that he did not need treatment, but if Mr. Franklin had known, he would have insisted. He encouraged NCIPC, in consultation with the TCAC, to develop some culturally appropriate posters, signage, and handouts that deal directly with elder falls if they do not already exist.
- Dr. Ballesteros responded that there is a website that includes a plethora of resources available from NCIPC directly geared toward older adult falls (e.g., posters, brochures, et cetera). While he was not sure if there were already culturally appropriate materials for tribes, there are at least materials readily available at this point. He thought the pictures spanned the population of the US, and noted that internally they could speak further about how to make some of the materials more appropriate for specific populations.
- CDR Billie added that NCIPC is working on culturally appropriate materials for the elder population that focus on Native Americans. Since coming to CDC, she realized that the agency's native-specific photographs and media are limited, so she began contacting tribal members to request photographs and media that they may be able to share. All of the photos that CDC uses must be cleared and released to CDC to use. She thought that most people were interested in showing their tribes in a positive way, so CDC is very interested in obtaining photos and media of happy, healthy families. This message has been disseminated through the Tribal Epidemiology Center conference calls as well.
- Lori de Ravello indicated that while she was not directly involved in this project, but the Immunization Program and HPV Team at CDC were developing Native American-specific materials. As part of that they did a photo shoot in Albuquerque of youth and families, for which they collected releases. There are books and CDs that can be reviewed. The photo shoot was focused primarily on youth immunizations, but there are numerous family photographs as well, including multi-generational families.
- Bridget Canniff mentioned that three of the Tribal Epidemiology Centers have been funded under a cooperative agreement from CDC through the Office of Minority Health and Health Disparities. They have produced an injury prevention toolkit that is Native American-specific that covers motor vehicles, child safety seats, fire and home safety, elder falls, and a fifth topic. This was a collaborative project between the Northwest Tribal Epidemiology Center, the California Tribal Epidemiology Center, and the Southern Plains Tribal Epidemiology Center. The entire toolkit is available on the CRIHB website.
- Mr. Petherick inquired as to whether anyone had considered drilling down into why the accident rates are so much higher than the rest of the population. It seemed like a lot of the focus had been on individuals and their need to wear seat belts and drive safely. Perhaps



there are other contributors, such as the roads being in poor condition or not being marked very well, people having to drive long distances to get to their jobs or purchase food, et cetera. It is important to better understand and document those reasons and take them forward to Congress, et cetera. If it is unsafe to walk somewhere, people are also not going to risk their lives working on other health issues (e.g., diabetes, obesity, inactivity).

- CDR Billie agreed, indicating that they had also listed some of the major risk factors on the website and the references because this is important to understand. While they focus on personal behavior quite a bit, it is also true that changing environmental conditions can greatly decrease injuries. On the Navajo Reservation between Gallup and Window Rock, New Mexico, there was a large number of pedestrian fatalities for decades. Rather than focusing on personal behaviors that were contributing, they put up lights. Based on the crash reports, they realized that the number one reason for a lot of the pedestrians being hit was that drivers could not see them. By adding the lights, the pedestrian fatalities dropped such that in some years there were none. It is important to understand the risk factors.
- Mr. Valdo shared a local example regarding collaborations between IH S, SAMHSA, CDC, and tribal programs. He comes from a small community of 3,500 tribal citizens on the reservation and 5,000 total enrolled in the community. In 2009, they experienced 9 successful suicides out of 18 attempts that they know of. This is a high number. Many tribal communities are very cultural, spiritual, and close knit. The US Census shows that tribal communities do not have a homeless population because they take in anyone. Families are highly multi-generational. However, there is something wrong when this many people under the age of 30 take their own lives, particularly knowing the support that they have. He agreed that they needed help, but also cautioned that many of these people who committed suicide were referred to IH S, were referred out, but then were referred back because there are no human resources or infrastructure. They can use BIA services in Albuquerque, but that is a 75-mile drive one-way. Some people do not even have vehicles. The federal government seems to continually pull back on their responsibilities to Native Americans. The federal government tells tribes to take over their 638 programs, yet they do not allocate the dollars to provide the services, and to some extent, they do not provide those services to tribal communities anyway. There is an increasing trend to place more of the support and financial burden on tribes, and it is called nice, flowery things like “638” or “self-determination.” While tribes want to do things for themselves, they still need help. There is a great report on the sexual trade of Native American women in Minnesota, which discusses historical trauma and all of the things that Native Americans have gone through: extermination, assimilation, infertilization, et cetera. There is a history that Native American people have gone through that they must get through [Shattered Hearts: Sexual Trafficking of American Indian Women and Girls in Minnesota; Published August 2009 by Minnesota American Indian Women's Resource Center]. It is important to develop trust locally, and to understand that there is a major hurdle already before every entering Native American communities. He acknowledged that representatives from CDC have good hearts and minds and want to help, but there are barriers that will limit what they are able to do. He echoed the importance of cultural sensitivity. Mr. Valdo works for a non-profit group that has its own fire safety video, and they use *Remembering When*<sup>TM</sup>. They helped develop their own fire safety video with their own languages and their own local faces because people in the small communities respond better to this. Tribal communities are oral and visual, so it is somewhat different from the Western model. Having tribal partners and reaching out to ask for assistance is important, but there are 565 federally recognized tribes and over 200 are in





Alaska alone. There is not one mass communication model available. It must be done in multiple streams and multiple systems.

- Dr. Crosby agreed that the NVDRS would definitely not pick up all of the suicides, and he agreed that more could definitely be done in terms of collaboration. NCIPC has worked with the IH S and SAMHSA on various projects, and has been involved in more intensive evaluations of communities that definitely have demonstrated that historical trauma, the magnitude of unemployment in communities, substance abuse, et cetera play a role in suicidal behavior among adolescents and young adults. Consideration must be given to how to address these issues in terms of what resources are available, what programs have been demonstrated to work, what programs have been developed specifically for American Indian communities. It is a small number, but there are a few. NCIPC worked with IH S to develop a natural helpers program for an Apache Tribe in Dulce, New Mexico. It is a matter of expanding the menu of programs that are known to work and finding resources to do it.
- Ms. Hughes thought the on-going discussion about collaboration and getting more minds working on the same issue was one of the themes they would hear repeatedly, and they are beginning to observe more progress in dealing with various issues. There is a constant reminder about resources as well. They have heard in other meetings that CDC has a lot of resources, and the tribes need to remind themselves to go to the CDC website to learn what is available that can be adapted. Even all tribes are different. One product is not going to work in all 565 federally recognized tribes, but there is a source to tap that can be modified for each tribe.
- Mr. Franklin requested that CDC work to place a link on the CDC and NIHB websites for the Remember When™ materials.
- Regarding collaboration, CAPT Snesrud agreed that helping tribes to better understand the resources available at CDC was critical (e.g., materials, points of contact, SMEs, et cetera). CDC is trying to be more accessible. She stressed that anyone who needed information should not hesitate to contact her or Dr. Bryan, who have the ability to connect people.
- Tim Gilbert noted that during the last TCAC meeting in Atlanta, there was an injury breakout session. Regarding the research agenda, if they saw something that aligned with Alaska's priorities, he wondered how they would go about working on a project together with NCIPC. Related to that, the position they find themselves in in Alaska for intentional and unintentional injuries is that the funding for their programs has been on a slow decline. They are compact in Alaska, so a tribal leader in the Alaska Tribal Health system may find himself or herself trying to decide what to invest in (colorectal screening, diabetes, injury prevention, or another problem). The numbers speak for themselves. They once had 22 designated FTEs addressing injuries in Alaska, and now have 4 or 5. It is probably a local problem, but he wondered how NCIPC might help. Alaska has great data. They have a trauma registry that they tap into, but what they do not have is the ability to make a case for injury prevention—a marketing campaign to raise the awareness of the importance of investing in this problem. Tying that back to what types of projects they might work on in partnership with NCIPC, he wondered how NCIPC invests in projects such as that.
- Dr. Ballesteros suggested that he look at NCIPC's Injury Framing Guide, which was one of the resources listed in Dr. Ballesteros's presentation. While not specific to Native Americans, the intent of that was about making the case for injury as a public health



problem. Even NCIPC is still trying to make that case, and have struggled with this for decades. The Framing Guide was NCIPC's attempt to get a collective, consistent message across about the issues of injury. Regarding the research agenda, the way NCIPC uses the agenda is that when they have funds available specifically for research (versus programs), they make sure that what they fund aligns with the research agenda. They consistently stay on that path in order to give their best effort to addressing the topics they deemed important in that agenda. Many of those will relate to tribal communities. When FOA's are published, tribes are eligible to apply for these funds. NCIPC has published some announcements that were specifically for tribes, and continue to look for opportunities to do that.

- With respect to who to call, CDR Billie stressed that she, CAPT Snesrud, and Dr. Bryan would be happy to help direct them in the right direction. Part of CDC's role is to provide technical assistance to anyone in the country who wants it.
- Dr. Crosby added that Alaska could coordinate its Injury Atlas with the Injury Framing Guide. Part of making the case is the magnitude of the injuries (e.g., morbidity, mortality, and cost). The Injury Framing Guide helps to package existing information to make the case.
- Dr. Antone inquired as to when the recommendations were expected to be published from the health disparities meeting that addressed adolescent suicidal behavior among American Indians / Alaska Natives and Latinos that Dr. Crosby mentioned.
- Dr. Crosby responded that SAHMSA offered to develop a specific password access website to which only the participants could contribute in terms of the recommendations. Originally, the recommendations were very general at the close of the meeting. The raw data will be entered into the website so that the participants can provide comments and make revisions, in order to develop more specific recommendations. He was not sure what the timeline would be, but expected the website to be set up within the next few weeks. Then it would be a matter of the participants providing their input.
- Mr. Antone pointed out that collaboration needed to occur in the federal and tribal communities. There is a consultation in March with HHS. From what he understood, a number of groups had sparked the focus on suicide. They need to come together to address this. Some things stood out to him regarding the health disparities meeting that addressed adolescent suicidal behavior among American Indians / Alaska Natives and Latinos. There was the idea of historical trauma hundreds of years ago, plus the infiltration of various religions, particularly Catholicism. There has been a loss of tradition, and there are differences between families. In December, they lost someone to suicide and the family did not want it to be known that that was the cause. However, everyone knew. They are considering putting something through Health Research Advisory Council (HRAC) as an addendum.
- Dr. Crosby inquired as to whether Mr. Antone received a copy of the original recommendations that came out of the meeting. Since the timeline for refining these may be too long, perhaps he could utilize the raw recommendations to refine himself. He offered to provide a copy to Mr. Antone of all of the original recommendations. He recognized that there is stigma in some families that is associated with shame. Not addressing it can contribute to the grief, and there are healing processes that a family or community have to go through if nobody wants to talk about it.



- Larry Curley observed that in all of the discussions he had heard throughout the day, there was constant reference to websites. There appeared to be an assumption that everyone and every tribe has access to the Internet. In Nevada, there are 27 tribes that are located in one of the most isolated parts of the country. One clinic in the last two weeks had a stock of H1N1 vaccines go bad because a power source went out. They had to scramble to find another source. Applying that to the Internet, the Internet relies on a reliable power source, but when that power goes down, there is no access to the Internet and all of the websites in the world are not going to come to you. He thought there was overreliance on technology, and that there was an underlying assumption that it was available everywhere. Regarding prevention, although there are 15 tribal clinics in Nevada and 13 are tribally managed and administered, there are no IHS hospitals in the state at all. As a result, the tribes in Nevada are highly dependent on contract health services funds. Those funds are received in October and are depleted by the end of February of each year. There was a meeting with the clinic health directors recently who were talking about people who presented for cancer treatment who were approved for initial treatment under Priority 1, but were denied follow-up treatments. Prevention is an oxymoron. It is not occurring in Nevada. He wondered of the statistics that were being collected how many of the deaths could be classified intentional because of denial of health care to their people who require follow up prevention care.
- Ms. Hughes noted that the first disparity that always came to the forefront in Indian Country was the funding disparity. Many of their problems could be made better if there was simply funding. Tribes know they are nowhere near having the funding needed to do what needs to be done, which brings them back to the collaboration discussion. They must ensure that they build contacts with all federal agencies to help them deal with the issues in Indian Country. In her lifetime, she does not expect to see the health disparities issues brought into alignment with the rest of the country, but a good goal would be for cardiovascular disease in Indian Country to be the same as for the rest America. She would like to see Indian Country receiving the same amount of funding that state and federal penitentiaries receive for their inmates. The incongruence in dollars for others versus dollars for American Indians / Alaska Natives comes up in every consultation.

## National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)

### Overview

**Wayne Giles, MD, Acting Deputy Director  
National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)  
Centers for Disease Control and Prevention (CDC)**

Dr. Giles extended his welcome to everyone on behalf of NCCDPHP. During this session, he discussed the burden that chronic disease has and the impact it can have in Indian Country, offered an over view of NCCDPHP, and highlighted some of the tribal collaboration and consultation efforts. Dr. Giles reported that chronic diseases are responsible for 7 of every 10 US deaths. Nearly half (49%) of Americans suffer from one or more chronic diseases. Chronic diseases cause major limitations in daily living for 1 in 10 Americans, and cause significant racial / ethnic disparities in health [Kung HC, Hoyert DL, Xu JQ, Murphy SL. Deaths: final data for 2005. *National Vital Statistics Reports* 2008;56(10). Available from: <http://www.cdc.gov/>

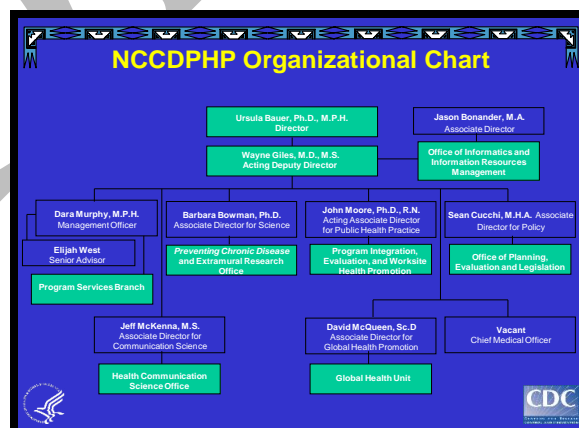


[nchs/data/nvsr/nvsr56/nvsr56\\_10.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf); Wu S, Green A. Projection of Chronic Illness Prevalence and Cost Inflation. RAND Corporation, October 2000; Anderson G. Chronic conditions: making the case for ongoing care. Baltimore, MD: John Hopkins University; 2004; Kung HC, Hoyert DL, Xu JQ, Murphy SL. Deaths: final data for 2005. *National Vital Statistics Reports* 2008;56(10). Available from: [http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56\\_10.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf); and National Center for Health Statistics. Health, United States, 2007. With chartbook on trends in the health of Americans. Hyattsville, MD: National Center for Health Statistics; 2007. Available from: <http://www.cdc.gov/nchs/data/hs/hs07.pdf>].

Chronic diseases are also costly. They account for about 75% of annual US medical care costs, and 98% of Medicare spending and 83% of Medicaid spending is for people with chronic conditions. That is, nearly every dollar of Medicare spending is for people with chronic conditions. Health care coverage costs for people with a chronic condition average \$6,032 annually, which is five times higher than for those without such a condition [*Partnership for Solutions, Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update.* Anderson G. Chronic conditions: making the case for ongoing care. Baltimore, MD: John Hopkins University; 2004]. Based on both the burden and cost data, the urgent reality of chronic diseases cannot be ignored. The investment in chronic disease prevention programs is essential in order to successfully address the nation’s health care crisis.

It is known that AI / AN community has its own language, culture, and history. It is also known that over 60% now reside principally in urban settings, and that as a whole, they are younger and poorer than the average US population. The five leading causes of death in AI / AN populations are: Heart disease (19.1%), Cancer (17.7%), Unintentional Injury (11.7%), Diabetes (5.9%), and Stroke (4.5%). These are followed by: Chronic Liver Disease and Cirrhosis (4.3%), Chronic Lower Respiratory Diseases (3.7%), Suicide (2.8%), Influenza and Pneumonia (2.5%), and Kidney Disease (1.9%) [Source: Health United States, 2008]. Although chronic diseases are among the most prevalent and costly health issue in the nation, they are preventable. Four key risk factors that contribute to most chronic diseases include tobacco use, poor nutrition, physical inactivity, and obesity and overweight. It is known that American Indians and Alaska Natives smoke more, engage less in physical activity, and have increasing obesity rates.

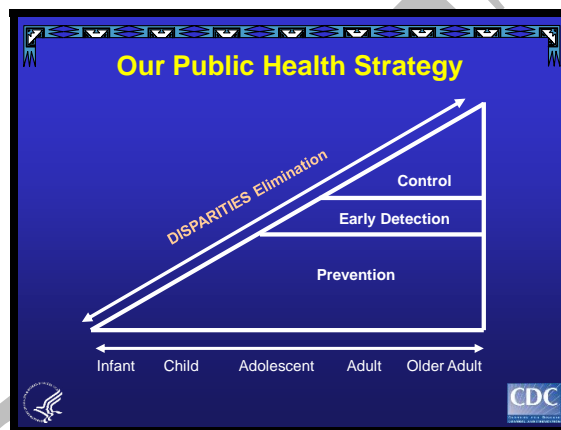
To address chronic diseases, the NCCDPHP organizational structure is as follows:





NCCDPHP is 21 years old. Notably about the center is that divisions are disease-focused, risk factor-focused, or population / setting-focused. The disease-focused divisions include: Division of Cancer Prevention and Control (DCPC), Division of Diabetes Translation (DDT), Division for Heart Disease and Stroke Prevention (DHSP), and Division of Oral Health (DOR). The risk factor-focused divisions include: Division of Nutrition, Physical Activity, and Obesity (DNPAO), Office on Smoking and Health (OSH), and Office of Public Health Genomics (OPHG). The population / setting divisions include: Division of Adolescent and School Health (DASH), Division of Adult and Community Health (DACH), and Division of Reproductive Health (DRH).

In thinking about the public health strategy, the burden associated with that, and the population impacted, NCCDPHP likes to use the following illustration to stress that prevention cuts across the entire life from cradle-to-grave:



NCCDPHP’s first priority is to prevent or delay disease, disability, and the associated costs. This can be done by avoiding tobacco use, increasing physical activity, improving nutrition, and maintaining normal weight. The second priority is early detection in order to find disease early and halt or reverse its course. This is done through cancer early detection, heart disease early warning signs, and addressing pre-diabetes. The third priority is effective disease management of conditions such as high blood pressure, high cholesterol, A1C, and obesity. Strategies include addressing lifestyle behaviors, self-management, preventive health care, and medication compliance.

NCCDPHP’s contribution to public health and the AI / AN community includes tribal grants, formal and informal tribal consultation processes, interagency agreements with HIS, and collaboration with the NIHB. Approximately 3% of NCCDPHP’s budget directly supports tribes or tribal organizations. The center’s engagement with AI / AN populations through IHS, direct tribal grants, through networks like the NIHB and the formal and informal Tribal Consultation process also helps to ensure that their investment is as collaborative, meaningful, and culturally appropriate as possible. NCCDPHP’s interagency agreements with IHS since 1990 involve DACH, DCPC, DRH, DHSP, DNPAO, OSH, and DOH. Across the center, total funding to tribes is approximately \$26.4 million on an annual basis. Compared with other centers, NCCDPHP is please to be on the high end of funding, and clearly understands the major impact that these dollars can have and the importance of addressing health disparities within AI / AN communities.



## **Division of Cancer Prevention and Control**

**Marcus Plescia, MD, MPH, Director  
Division of Cancer Prevention and Control (DCPC)  
National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)  
Centers for Disease Control and Prevention (CDC)**

Dr. Plescia indicated that he was fairly new in his role as Director of DCPC, having come to work at NCCDPHP about six months previously. Prior to this, he worked in chronic diseases in North Carolina.

He reported that DCPC provides national leadership in developing and implementing a comprehensive, public health approach to cancer control, from primary prevention to end-of-life palliative care; focuses on risk-reduction, early detection, surveillance, cancer survivorship, education, and reducing health disparities; and collaborates with partners (e.g., state, tribal, and territorial health agencies; voluntary and professional organizations; academia; other federal agencies; and the private sector). In FY 2010, DCPC was appropriated \$370 million for its cancer prevention and control activities, including four national programs and two national education campaigns. Approximately \$14 million are provided through CDPC for projects that serve AI / AN communities, largely because they run fairly large screening programs.

The National Program of Cancer Registries (NPCR) provides data for 96% of the population. Along with NCI's SEER, 100% of the population is covered. Misclassification of AIs / ANs has created under-representation of disparities in cancer data. In 2008 and 2009, CDC linked NPCR and IHS patient registration data to produce more accurate AI / AN cancer incidence. This allows tribal organizations to plan and implement cancer control efforts. This has been so successful, they are now considering linking the IHS patient registration data with the National Death Index (NDI).

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) includes screening programs that are funded in all 50 states, DC, 4 US territories, and 12 American Indian / Alaska Native organizations. These programs provide breast and cervical cancer screening and diagnosis to low-income, uninsured, and underinsured women. Services include clinical breast examination; mammograms; pap tests, diagnostic testing for women with abnormal results; surgical consultation; and referrals to treatment. Approximately 5% of women screened through NBCCEDP are AI / AN women. This program also offers technical assistance to increase breast and cervical cancer screening for tribes and states with large native populations. NBCCEDP targets low-income women with little or no health insurance. Racial and ethnic minority women comprise priority populations in the program, which has helped to reduce disparities in cancer screening and health outcomes. From 2003 to 2007, pap smears were provided for 84,000 AI / AN women and about 45,000 women received mammograms. This program has a lot of reach, particularly for those who do not have ready access to IHS services.

The Colorectal Cancer Control Program (CRCCP) funds programs in 26 states and 4 tribal organizations. CRCCP utilizes a population-based approach to increase screening rates to at least 80% by 2014. The program is integrated with a public education campaign, Screen for Life, to increase awareness of the importance of screening. In 2005, AIs / ANs had the second highest incident rate for colorectal cancer. Routine screening can prevent cancer. FY 2010



funding for colorectal cancer-related activities will be \$44 million. Four tribal organizations received funding for CRCCP: Alaska Native Tribal Health Consortium, the Arctic Slope Native Association, South Puget Intertribal Planning Agency, and the Southcentral Foundation.

The number of new colorectal cancer cases could be reduced by 76% to 90% if all precancerous polyps, abnormal growths in the colon or rectum, were identified using screening tests and removed before turning into cancer. However, only half of all US adults aged 50 or older have been screened appropriately for colorectal cancer. While screening rates are slowly increasing, disparities still exist in screening test utilization. It is important to integrate efforts with other chronic disease prevention efforts.

The funding will support screening and diagnostic follow-up care, patient navigation, data collection and tracking, public education and outreach, provider education, and an evaluation to measure the clinical outcomes, costs, and effectiveness of the program. The population-based approach covers low-income, uninsured, and underinsured men and women between 50 and 64, as well as the insured.

The Tribal Comprehensive Cancer Control Program (TCCCP) offers an integrated, coordinated approach across the cancer continuum. Tribal Cancer Plans have been developed in 7 tribes and tribal organizations, the purpose of which is to assess the cancer burden; address the needs of at-risk populations; create cancer prevention priorities; and build infrastructure to increase AI's / ANs' access to cancer screening and treatment. The steps include plan implementation and fostering collaborations with partners.

DCPC AI / AN-focused activities include data linkages in NPCR to improve cancer burden data; research on AI's / ANs' experience with cancer prevention and treatment; work with Fond du Lac, White Earth, Red Lake tribes and the Alaska Native Medical Center to survey prostate cancer patients' experience with care in urban health centers; colorectal cancer prevention projects with Tribal Epidemiology Centers; and provision of tribal liaisons to provide technical assistance to CCC, BCC, and CRC grantees and to work with key partners, including HIS.

Opportunities include continued work with NPCR and IHS to link cancer incidence data for AIs / ANs in order to gain greater insight into the cancer burden for AIs / ANs; provide support for tribe and tribal organization cancer prevention and control programs (especially breast, cervical, and colorectal cancer prevention programs; and integration with tribal comprehensive cancer control plan efforts); and continue research into AI / AN cancer disparities (e.g., burden of disparities, causes, and effective interventions to reduce disparities).

The issue of survivorship is a new area that NPCR is working on. At this juncture, people with cancer can be effectively helped and cured. But again, as with many underserved populations, people go through a great deal of pain and suffering in being treated for cancer and an enormous amount of money is spent on treatment, and they survive. But then they are forgotten, are lost in the system, and return to not having very good access to care. This is a public health problem that they want to deal with. There are 50 million cancer survivors across the US today, which is an area NPCR is interested in engaging in with AI / AN in an effort to be more effective.



## **Discussion Points**

- Mr. Trudell wondered how many AI / AN men over the age of 50 have actually received colonoscopies, because it is a contract health issue and probably will not be paid for.
- Dr. Plescia responded that a couple of their epidemiologists, who are physicians, are in some of the tribal areas. They have used various providers for those services. He agreed that is an issue to obtain a colonoscopy, particularly for people who are in more remote areas where there are no services. This is a major challenge, with which the division continues to struggle.
- Mr. Petherick said he appreciated the slide pertaining to opportunities. He is with the Cherokee Nation, which operates one of the Comprehensive Cancer Control Plans. Not only within their plan, but also within the IH S budget formulation process, a problem they have experienced is that cancer ranks high in health priorities. However, when having to make tough budget choices, it is not a budget priority. It would be helpful to understand the true cost of cancer in Indian Country so that they could all be better advocates for cancer prevention and control in Indian Country.
- Dr. Plescia replied that their division is engaged in a number of research activities, and have begun to put together a team of economic researchers. He will take this suggestion back to them.
- Mr. Valdo indicated that his mother was diagnosed with Stage 4 colorectal cancer about seven months previously, and is currently receiving chemotherapy. It was clear that the division is aware of the issues (e.g., lack of resources, lack of testing, lack of screening). They are fortunate that his mother worked for an enterprise that provides 100% of medical benefits, yet she never got tested. She went to IH S and complained of symptoms, but was never tested even though she had insurance. There is also a contract health issue. The system is broken. It is difficult to allocate resources adequately and in the best locations to try to prevent diseases. He wonders how he failed his mother. She is 54 years old with Stage 4 cancer, so this is very near and dear to him. With that in mind, Mr. Valdo reiterated the importance of collaboration and coordination. He also wondered how they could fix a system that does not talk to each other, does not utilize all of the resources that are available, tries to push people off elsewhere even if they have coverage, et cetera. When the IH S facility is the only facility within 60 miles, as many complaints as there are about it, that is where people are going to go. When IH S is not providing necessary services, such as screening, there is something wrong.
- Dr. Plescia thanked Mr. Valdo for sharing his personal story. He said he thought that approximately 50% to 60% of people were taking advantage of the screening tests. Obviously, many people are still slipping through the cracks. It is not just ability to pay. People who have good insurance are not getting their colorectal screening exams. There are many reasons for that, which need to be better understood. The division is fortunate to be able to use those screening funds much more broadly, and to really look at all barriers, not just cost. Hopefully, this will help to increase the rates of screening, which remain widely underused.
- Ms. Hughes indicated that the Bemidji area is also very low in rates of accessing screening programs. Colorectal cancer is very high in this area. Even if people have access to IH S,





people are not going in for any of these specific tests. The Oneida Tribe is a highly populated area. They have access to a lot of medical services. The IH S clinic is not the only option. However, tribal members will primarily go to the IH S clinic before they will go to private clinics and hospitals. So, they instituted a program almost a year ago in which they issue a card to anyone who comes in who is over the age of 50, which has a standard checklist of what everyone should get on an annual basis (e.g., colonoscopy, mammogram, tuberculosis test, et cetera). There is an incentive for people who check off a certain percentage of the items on the card to receive a gas card. Still, the awareness factor continues to be an on-going battle. Everyone knows what is available, but until it becomes personal, people do not pay attention to the consequences. But, it is so easy to prevent in the first play. It is an on-going communication issue that must be addressed over and over.

- Ms. Manuel said she thought that overall in Indian Country, people do think, "It won't happen to me, or my family, or that's not an Indian thing." In her area, they have educators but it is still difficult to convince people to go to screenings until it happens to someone in their family. She has an aunt who has had cancer three times. She has finally gotten involved in the activities, and got the family involved. Because of this, they found out how many family members had cancer and did not know until the last minute when nothing could be done to save them. Her aunt is now involved in the American Cancer Society (ACS) walks to collect funding and has encouraged the rest of the family to get involved. Ms. Manuel said that even though screenings are offered free, they hardly see anyone take advantage of this opportunity. Recently, they had a mammogram clinic in which they took a van out to the community. Only 32 people out of 100 women who were called showed up. That was sad to see. When she spoke to some of the people there and told them to go to the van because many people had not shown up, some of the people said they did not really need it. They must start educating in some other way so that they understand that this can happen to them.
- Mr. Secaturo indicated that in September, his wife was diagnosed with cancer. Just like Ms. Manuel said, unless someone has been through it, they will not think much about it. His wife had to go through treatments and she was placed in isolation. People at home do not think about it. At his clinic, the no-show rate is about 60%. Even he has not shown up for screenings. They wanted to check his ears, and he put it off three times. The CHR kept demanding that he be seen. Finally, he went to the VA who told him he could not hear. Because he is a veteran, he is now receiving disability compensation. They have tried many times to figure out why people do not show up for screenings. Still, they must keep trying.
- Mr. Trudell pointed out that everyone in the room and at the table had probably been touched by cancer. It is a shared fault because people do not use the IH S facilities the way that they should, not because they do not want to, but because they believe it will not do them any good anyway because there will be follow-up treatments that are not paid for. It is going to a continuing theme that people can go for all of the screenings they like, but if they need follow-up exams and / or treatment, they will not receive these. Aberdeen Area has a good breast screening program. A van comes to the clinics and hospitals. Sometimes those notices come out really early, but if a visit has to be postponed, by the next visit people have forgotten and have not been notified about changes. That accounts for some of the 60% no-shows. Because of the priority system under which the IH S and all of the tribal clinics have to operate, if someone is not a Priority 1, they will not receive service. They may receive drugs, but if they need a referral out and are not a Priority 1 for other



screening or further determination of the seriousness of a disease or potential disease, they will not receive it. This is why people simply do not go back to IHS.

- With regard to reasons for not taking advantage of screenings, Mr. Valdo indicated that CHS dollars are paying for screening. IHS facilities are not even doing this. Many people see their tribal facility as being their medical home, yet they are sent for something that they are very uncomfortable doing already outside of their medical home. He has heard his own cousin make the excuse, "Well, I'm not going to get checked, because who is going to pay for it if I find out it's there? I would rather just let it take its course." If they cannot educate their own families to get screened, he does not know what to do. Even as the Chair of the NIHB, he has no answers. The California Area Office may authorize funds if someone is on their death bed. Unfortunately, that is a reality. The other problem is that these things do not get checked for so long. When his nephew was diagnosed with leukemia at the age of one. He is now two years old, and there has been a huge burden on the family. His parents have to take him about two hours away for treatment, and often have to stay for a month. Anytime his nephew even catches a cold or infection, the whole family must figure out how to help. This is not an Indian-friendly facility. They must travel to Oakland Children's Hospital, which is about as far away from Northern California Indian Country as they could possibly be. When his grandmother went to visit his nephew, she stepped on a hypodermic needle on the sidewalk of the facility. This is a reality of what his people put up with. Mr. Valdo said he also thought they were not doing enough for their young men, in terms of educating them about screening. They have to reduce the stigma. Outreach and education cannot just be to the IHS facility, because many areas simply do not have such facilities. There must be more creative ways to get messages out to people.
- Ms. Begay mentioned that cancer is the third leading cause of death in the Navajo Nation. The Navajo healing ceremonies coincide with Western medicine of prevention and wellness. She appreciated the number of Navajo people working at CDC. She was very pleased and touched to hear some Navajo voices at this meeting. The Navajo culture, way of life, and the blessing ceremony are very closely tied to healthy living. The activities within the blessing ceremony are all about walking in beauty. For women who are pregnant, the ceremony is about prenatal care, childhood, adolescents, and puberty. There are many chants and blessing all the way through the later years of life praying for the good way, quality of life, and long life. In terms of cancer, there are barriers to accessing health care for men and women. She believes the greatest obstacle in Indian Country, and specifically for Navajo people, is fear of being told that they have early signs of cancer or may have cancer. Navajo people were sent elsewhere for screening, treatment, and continued care until 2007 when a cancer center was built in Gallup, New Mexico. It is still a great distance for people in the Western part of the nation to travel there or elsewhere. Another issue is that there is no family support. Contract health service program and tribal resources are limited, but family support is needed. CDC needs to understand that the blessing and cultural healing programs are critically essential, but Medicare and Medicaid do not cover these. This needs to be considered. She noticed one of the bullets in the presentation spoke to that, and that it needed to be followed through on.
- Ms. Hughes stressed the importance of creating awareness so that prevention and cure could occur.

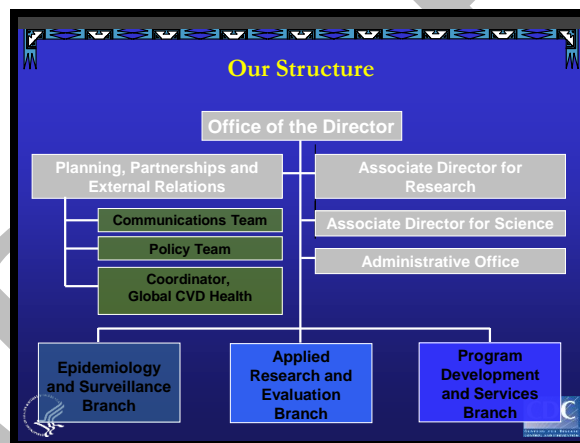


### **Division for Heart Disease and Stroke Prevention**

**Nell Brownstein, PhD  
Applied Research and Evaluation Branch (AREB)  
Division for Heart Disease and Stroke Prevention (DHDSP)  
National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)  
Centers for Disease Control and Prevention (CDC)**

Dr. Brownstein reported that DHDSP’s mission is to “Serve as the nation’s public health leader for achieving cardiovascular health for all and eliminating the disparities in the burden of heart disease and stroke. CDC is a “science-based” organization, meaning that they have access to public health data and need to use this information to propose informed solutions. DHDSP has achieved much of its work through its connections, and value its partnerships and opportunities, such as this meeting, to share the division’s thoughts and information. DHDSP’s programs translate science into action. They can further define these pieces of their perspective into the following core functions: science (surveillance, research, evaluation), connections (partnerships, resources), and action (programs).

The division’s organization structure is as follows:

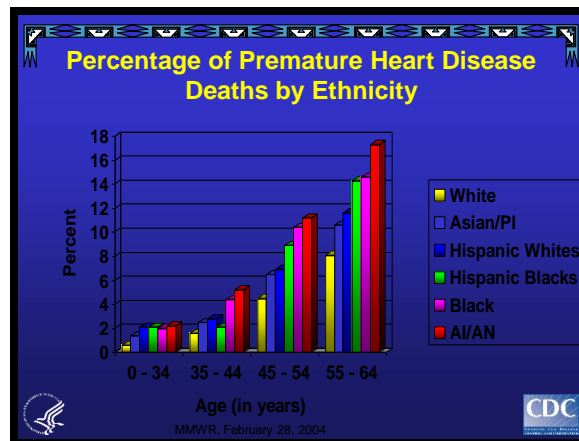


DHDSP has three branches. They have staff who analyze and detect problems, and they are planning to do much more intense work on data in order to better understand what is occurring in Indian Country. They also have staff who translate science into practice and help to evaluate the division’s programs. The program services staff assist with the WISEWOMAN and state heart disease and stroke prevention programs.

Program priorities are to control high blood pressure, control high blood cholesterol, improve emergency response, improve quality of care, increase awareness of signs and symptoms of heart attack and stroke and the need to call 9-1-1, and eliminate disparities. Strategies for addressing priorities include focusing on policy and systems change; affecting population-based change; ensuring cultural competency; engaging partners; and working at policy and systems levels within settings (e.g., worksites; health care; community; schools).



The heart disease problem in Indian Country is very large, which is of great concern. Diabetes increases the risk for heart attacks as well. The number of people in Indian Country who have heart disease (16.4%) is much higher than in any other population in the US: Black (9.9%), Asian (7.5%), and Hispanic (7.4%) [MMWR, Vol 52, Number 47, REACH Data, Nov. 28, 2003. p 1148-1152]. In addition, more people in Indian Country die earlier from heart disease than any other group in the US, as illustrated in the following graphic:



Data pertaining to age-adjusted prevalence of self-reported myocardial infarction by sex, race, and education level in the entire US adult population aged > 18 years show that males have a higher prevalence of myocardial infarction than women. American Indian / Alaska Natives and multi-racial respondents had the highest prevalence of myocardial infarction. Blacks and Whites had similar overall prevalence estimates. Asian and Hispanic respondents reported less myocardial infarction than Whites, although the estimates were not statistically significantly lower. Roughly twice the proportion of those with less than 12 years of education reported myocardial infarction when compared to college graduates. The prevalence of myocardial infarction increases with advancing age. The following chart shows the prevalence of myocardial infarction:

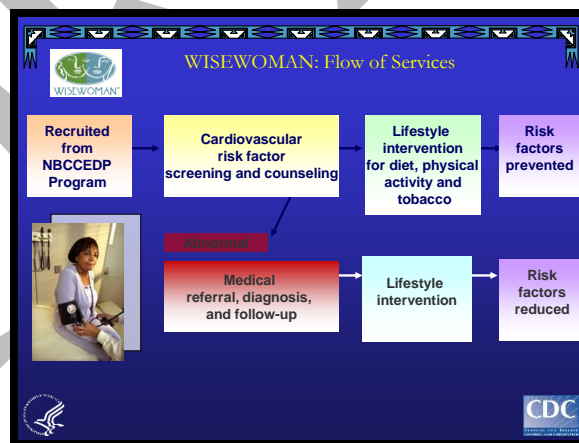
	% ≥18 Years	CI	
Sex	Male	5.4	5.3-5.6
	Female	2.9	2.8-3.0
Race	White	4.0	3.9-4.1
	Black	4.0	3.7-4.4
	Asian	2.8	1.7-4.5
	Hispanic	3.4	3.0-4.0
	AI or AN	7.5	6.0-9.4
	Multiracial	6.4	5.5-7.4
Educ.	< 12 yrs. Educ.	6.0	5.6-6.4
	High School	4.5	4.3-4.7
	Some College	3.9	3.7-4.1
	College Grad	2.9	2.8-3.1
Overall	4.1	4.0-4.2	



DHDSP has had the good fortune to work with staff at the Native American Cardiology Program as their partners on the Native American Time to Treatment Intervention Evaluation Study (NATIVE Study). Dr. Rick Brody noticed that people from Indian Country were presenting very late after having a heart attack. While “time is money” for a heart attack “time is everything.” Following a heart attack, parts of the heart begin to die because they are not getting enough oxygen and nutrients, but if an ambulance is called, they can begin treatment right away, which can make the difference between life and death. Of the 145 patients that Dr. Brody followed at the Cardiology Clinic, he noticed that 17 people did not report until 12 to 24 hours after having a heart attack, and 34 people did not come in until after 48 hours. When he followed up to learn the reason for their delays, he found out that some people went to traditional healers, others had mild symptoms, and misunderstanding the signs of a heart attack. Other reasons included denial, lack of telephone, personal transportation issues, hospital / EMT delay).

DHDSP has a wide variety of programs, such as the WISEWOMAN Tribal Programs in Alaska and South Dakota. Montana has also been very active as one of DHDSP’s funded states. They have conducted a very specific heart attack campaign on the Crow Reservation, a very specific stroke campaign on the Flathead Reservation, and are conducting blood pressure and cholesterol work with patients at three Urban Indian Clinics. Oklahoma is working to collect more information on blood pressure and cholesterol among Native Tribes so that they can better provide prevention activities (e.g., CVH Examination Survey). Minnesota has a CHW intervention to improve blood pressure control.

DHDSP shares the WISEWOMAN program with the NBCSP. In addition to cancer screening, native women are also screened for cardiovascular risk factors (e.g., blood pressure, cholesterol, weight, blood sugar, and smoking status), and they also receive assistance in healthy eating and increasing physical activity in ways that are more like their ancestors. The WISEWOMAN flow of services is illustrated in the following graphic:





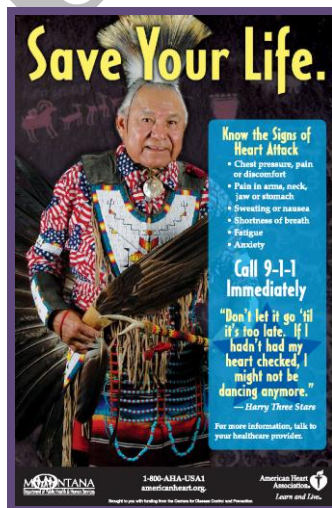
The WISEWOMAN Alaska program has implemented a statewide media campaign for native women about the warning signs of heart attacks, which can be found at the following address:

<http://www.partners.hss.state.ak.us/takeheart/AlaskaWomenTakeHeart.htm>. This is one of their posters:



The program has a toolkit that includes book marks, bingo cards, event planning activities, and radio spots. Alaska has won some major media awards for its products, as has Montana.

Montana Department of Health and Human Services launched a campaign with the American Heart Association on the Ft. Peck Reservation. The following is a poster with Harry Three Stars, who is a known pow wow dancer, urging others to know the signs of a heart attack and call 9-1-1:





DRAFT



Dr. Brownstein then discussed some research in which she has been engaged, Reducing Time to Treatment for Myocardial Infarction (MI) for Rural American Indians and Alaska Natives, that offers an opportunity. They were interested in better understanding why tribal people did not know all of the signs of a heart attack and why they were presenting for care so late following a heart attack. The contractor for this project is an Indian-owned company. The first phase is underway, which includes interviews with tribal health care providers, community leaders, and individual community members and focus groups with community members to get their perspectives on delays to treatment, key myocardial infarction messages to AI / AN populations, and recommendations for healthcare providers.

The stories they are hearing are very rich. She had heard that heart attack was not even “on the radar screen” for people in Indian Country because they are too busy. That is simply not true. All of the community members had members of their extended families who had died from a heart attack or who were disabled as a result of a heart attack. People really opened up and told their stories. The primary message they heard was that they did not want other people to go through what they had. Some of the stories people told regarded poor relationships with their providers. Providers were not even asking them about their history of heart disease or heart attacks, or telling them about any signs of heart attacks other than chest pains. An elder who went for a walk every day of his life did not go out one day for his walk. His family asked him why, and he told them that he did not feel that he could make it home due to terrible fatigue. He had a heart attack. Not much is being done for people after they have a heart attack either by their primary care providers. One woman confided that her doctor never told her whether she could have relations with her husband following a heart attack.

The barrier for not getting in quicker after a heart attack seems to be distress to the system. One suspicion providers have is that people are coming in claiming to have chest pains because they want to acquire pain medications. Another area that elicits a lot of distress is that when people do come in, they are transferred to hospitals far away, they have no transportation to get back home, and their families have no transportation or funds to stay in a hotel near where they are hospitalized. Mr. Franklin alluded to that issue when he talked about how it took four hours for his family to get to cancer treatment. Though they are not finished analyzing the data, it appears that health care providers need recommendations for improvement at IH S and Tribal Clinics. Because it is known that tribal members have not been getting all of the information about the signs of a heart attack, DHDSP wants to improve that. They look forward to working with and getting feedback from the TCAC on this project. Another product this division has produced is a community health worker source book, which is a training curriculum for preventing heart disease and stroke.

### **Discussion Points**

- Ms. Hughes emphasized that education and awareness was an important component. This needs to move beyond the consumer level. The provider needs to ask the appropriate questions. Unfortunately, Tribal Clinics are so overwhelmed, it is difficult to get into any department because the waiting list is always long. Even with a triage department, it is difficult to get a short turnaround because the intake person asking the question is not asking enough or the right questions, so situations are not being diagnosed as something





that needs to go to triage immediately. That occurs in private hospitals when people call or go to the emergency room. This is an area where they need to have the professional people who are trained asking the questions. She knows chest pains mean there is the possibility of a heart attack, but she does not know all of the other symptoms. However, if someone asked her the right questions, she would respond appropriately and perhaps there would be a quicker trip in for the necessary treatment.

### **Division of Reproductive Health**

**Myra Tucker, Tribal Liaison**

**Division of Reproductive Health (DRH)**

**National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)**

**Centers for Disease Control and Prevention (CDC)**

Dr. Tucker noted that she attended the first TCAC meeting, and was excited to see the work moving forward and the process of educating CDC and garnering CDC resources to work on behalf of tribes in an effective manner. This group also has personal meaning for her in that, since the last time they met, she became the Tribal Liaison for her division because CAPT Snesrud assigned that to her name on the agenda and it stuck.

For those wondering why DRH was housed in NCCDPHP, the honest answer is that it was a political decision. At the same time, there is a good rationale for reproductive health to be considered in the whole circle of life or the life cycle. DRH deals with women before, during, and after pregnancy; infants; and children. They are increasingly learning that physiologically, pregnancy's stress to a woman's body offers a window into a woman's health and an opportunity to affect her lifelong health (e.g., gestational diabetes) and infancy and childhood as the foundations of health. Thus, in many ways, NCCDPHP turns out to be a good fit for DRH.


DRH's mission is to "Promote optimal reproductive and infant health and quality of life. There are numerous resources and tools at CDC and in DHR that are relevant to developing public health infrastructure and epidemiologic capacity within tribal health organizations." Resources can be found at the following web address: <http://www.cdc.gov/reproductivehealth/>. To accomplish its mission, DRH works with partners to conduct epidemiologic research and surveillance; support scientific and programmatic development within states and tribes; provide technical assistance and consultation; and translate research findings into health care practice, public health policy, and health promotion.

As evidenced by the following table, there is a lot of work to be done with tribes:



Selected US Health Indicators, US White and American Indian Populations

	US Whites	AI/AN
Life expectancy	78.3	74.5
Infant mortality	5.8/1000	8.1/1000
Maternal mortality	9.9/100000	12.5/100000
No PNC, 1 <sup>st</sup> trimester	11.1%	30.1%
% Smoking in pregnancy	13.8%	18.2%
SIDS death rate	55.4/100000	111.6/100000



Based on these data, life expectancy for AI/AN is about four years shorter than for Whites in the US. Infant mortality is higher, maternal mortality is higher, lack of prenatal care is more than twice as high, smoking during pregnancy is higher, and death from sudden infant death syndrome (SIDS) is twice as high.

DRH's previous work with tribes includes 30 Tribal Behavioral Risk Surveys and research titled: *Risk Factors for Sudden Infant Death Syndrome among Northern Plains Indians*. Current work with tribes includes capacity-building, surveillance, research, and emergency response. Cross-cutting themes include working with tribal entities for all activities; and providing appropriate data / enhancing the knowledge base. An important effort DRH is making is to determine how to acquire more local data for local decision making. CDC has a lot of expertise in these areas, and wants to work closely with its tribal partners to ensure that tribal organizations have that expertise and capacity as well.

Examples of the kind of tribal work the DRH is engaged in include the publication of a *Maternal and Child Health Journal* special AI/AN issue titled, "Research for Maternal and Child Health Practice in American Indian and Alaska Native Communities." In reviewing the scientific literature on AI/AN maternal and child health five years ago, DRH found that the literature relating to AI/AN was that less than 1% of the data even mentioned American Indians or Alaska Native mothers and infants. When they were mentioned, it was usually in the context of what Dr. Tucker refers to as "awfulizing," meaning a lot of descriptive data about what is wrong and what the disparities are. The purpose of the special journal was to increase the amount of relevant studies, moving beyond descriptive studies to include evaluations of interventions. It is known that the disparities exist, but something must be done about it. This journal includes input from tribal partners regarding avenues for intervention in order to shift the discussion to address what is working and how to move forward. Dr. Tucker stressed that her excitement about the tribal consultation process was because TCAC, more than any other advisory group she had observed at CDC, brought the issues right down to the personal level and what happens to people related to the work that CDC does.

The largest surveillance system in DRH is the Pregnancy Risk Assessment and Monitoring System (PRAMS), which is conducted in 35 states. A survey goes to new mothers that asks them about their experience during pregnancy and the health of their babies. This is one of the only sources of population-based data about new mothers and their babies in the US that is available for American Indians. In the 10 states that have 5% or more American Indians in their population, American Indian women generally are not high responders. The response rates are



about 60%, with the exception of Alaska and Oklahoma. Therefore, one of the discussions they have been having in the division over the last five years regards how PRAMS can work more effectively with tribal communities so that these data can be available for local use. South Dakota Tribal PRAMS showed people how to do that. They won an award in 2009 for a point in time PRAMS led by the Yankton Sioux Tribe. The South Dakota Tribes and the Yankton Sioux have provided a template for what works effectively with tribes by obtaining data locally and then returning those data for local use. Dr. Tucker said she was proud to report that the South Dakota PRAMS project had a response rate from American Indian women of over 70%. Part of DRH's work pertains to how to use what was learned from this experience to ensure that CDC surveillance systems in these states work on behalf of tribes. There is now a model, and it is within their reach.

With respect to future directions, Dr. Tucker believes that CDC should maximize the use of existing data systems on behalf of AI/AN maternal and child health; and that tribal data systems and tribal epidemiology programs should be developed.

### **Division of Adolescent and School Health**

**Linda Crossett, PhD**  
**Research Application Branch (RAB)**  
**Division of Adolescent and School Health (DASH)**  
**National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)**  
**Centers for Disease Control and Prevention (CDC)**

Dr. Crossett indicated that she had recently been given the lead for enhancing previous, yet minimal, AI/AN activities with partnerships within DASH, outside of CDC, and with all of the tribal units throughout the country.

DASH is somewhat unique at CDC in that it is one of the few divisions that funds education agencies throughout the country instead of health departments. When funds directly go to an agency in each state that is funded, they do have to have a memorandum of agreement with the state health department, and then a person is funded in that agency through DASH as well, so that there are two people at fairly high levels in the education and health agencies to address 6 categories of risk behaviors for young people that in unintentional injuries and violence; alcohol and other drug use; sexual behavior; tobacco use; dietary behavior; and physical inactivity.

Many people think of school health as being only health education, but DASH does much more than that. DASH enables partners to plan and implement effective policies and programs; synthesize and apply research; monitor health risk behaviors and school health policies and programs; and evaluate the effectiveness of policies and programs. DASH has three surveillance systems: Youth Risk Behavior Survey (YRBS), School Health Policies and Programs Study (SHPPS), and School Health Profiles (SHP). Like the theme echoed throughout the day, DASH has limited national data on American Indians / Alaska Natives. They have pockets of data, but is in its infancy in collecting these data. DASH views this as one of their priorities.

DASH believes in a coordinated school health approach and has developed numerous tools to help schools implement science-based, effective programs. Other divisions within CDC, other federal agencies, such as USDA, and national non-profit organizations have also developed high quality tools to help schools make a difference. The bottom line is that DASH has a strong,



research-based agenda for action and there is now a wealth of technical assistance resources available to help schools take action. So there are no good excuses really for failure to take action. The following are just a few examples:



With respect to specific activities addressing risk behaviors among American Indian and Alaska Native youth, through a series of contracts with Westat, CDC provides comprehensive technical assistance to sites conducting the YRBS, including the Bureau of Indian Affairs (BIA) and Navajo Nation (or near the reservation if enrollment was at least 50% Navajo), working with the Indian Health Service. The BIA first conducted a YRBS in 1994 among students enrolled in grades 9 through 12 in BIA-funded schools. Since that date, the BIA high school YRBS was conducted in 1997, 2001, 2003, and 2005. The BIA middle school YRBS (grades 6 through 8) was conducted in 1997, 2000, 2003, and 2005. The Winnebago Tribe and Cherokee Nation of Oklahoma have received funding support for administration of the YRBS. They also hope that these two groups will be models for other tribes. For the first time, DASH is also funding tribal governments to implement school health programs. The Nez Perce Tribe in Idaho received funds for DASH's coordinated school health program, and the Cherokee Nation of Oklahoma received HIV education funding and YRBS funding. All of the activities are supported through state education agency cooperative agreements. DASH also offers training in many of its evidence-based tools that will help schools address these risk behaviors. They have a professional development consortium. Several of the states, and recently the Cherokee Nation, have taken advantage of some of DASH's professional development training.

DASH was part of the recent Expert Panel: "Adolescent Suicide: Addressing Disparities through Research, Programs, Policy, and Partnerships" in September 2009. In addition, DASH has an article in clearance titled "Health Risk Behaviors among American Indian and Alaska Native High School Students in the United States, 2001-2007." DASH is very proud of this article. They originally intended to develop a website, but then realized that they did not have comparable data from various areas, so they combined years and data and have some methodologies that are explained in the article. They are publishing this article first so that they can explain how this was done due to lack of a broad spectrum of risk behavior data.

Opportunities include training and professional development; expansion of funding opportunities to support implementation of the YRBS and school health programs; and collaboration with other divisions and offices across CDC. Dr. Crossett stressed that DASH is prepared to



collaborate stronger with tribes. Most information about resources available from DASH (e.g., tools, regional training, et cetera); however, she appreciated the comment made earlier by Mr. Curley about some areas not having internet access. Therefore, she indicated that she would inform CAPT Snesrud, Dr. Bryan, and TCAC through other means as well.

### **Division of Oral Health**

**William Kohn, DDS, Director**

**Division of Oral Health (DOH)**

**National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)  
Centers for Disease Control and Prevention (CDC)**

Dr. Kohn indicated that CDC's Division of Oral Health (DOH) is currently a very small group, with 28 employees with a wide range of responsibilities nationwide. DOH consists of four essential, interrelated components that support the efforts of states to strengthen oral disease prevention and health promotion programs and to ensure the safe delivery of dental care. DOH's vision is "A nation where all people enjoy good oral health that contributes to leading healthy, satisfying lives" and its mission is to "Prevent and control oral diseases and conditions by building the knowledge, tools and networks that promote healthy behaviors and effective public health practices and programs."

Dentistry separated itself from medicine years ago, so they are always trying to remind people that the mouth is part of the body and that one is not completely healthy unless they have good oral health as well. DOH is a good fit within NCCDPHP because oral disease is a chronic disease. Dental decay is the most chronic disease of childhood. Once in the permanent teeth, it can be repaired, the damage is for life. DOH's focus is really on the prevention of oral disease first, followed by control. They primarily focus on tooth decay, gum disease, and oral cancer. In some ways it is easy, but can be very complicated moving across all of the implications of those diseases.

DOH does not implement programs. Its primary activities are to strengthen the nation's oral health infrastructure; build the evidence base for and extending the use of proven strategies to prevent oral diseases; enhancing efforts to monitor oral diseases and conditions; disseminate effective prevention practices to health professionals and the public; and provide guidance on infection control in clinical dental settings. The public health infrastructure in states and in Indian Country has really suffered, and the oral health departments tend to be cut first when there are budget crunches. This has always been a struggle, so DOH provides grants to states to help build up their oral health infrastructure. They have primarily worked with water fluoridation programs and school-based sealant programs. DOH is the national authority on infection control in dental offices. This division's history has really been in water fluoridation and infection control. It has only been in the last 10 years that DOH got more involved in research on prevention intervention and collecting data, so its impact is yet to be felt in some areas.

Activities and programs include the state department of health infrastructure development cooperative agreements; guidelines and recommendations; national oral health surveillance systems for oral health indicators, state synopsis, and oral health questions in surveillance systems (e.g., NHANES, BRFSS, PRAMS, NHIS, MEPS, and Healthstyles); and Healthy People 2010 / 2020. Most of DOH's tribal activities have been with IH S. Specific AI/AN efforts have included work on Healthy People 2010 / 2020 objectives; assistance in 2009 developing the Alaska YKHC Epi-Aid on caries in children; provided funds for water fluoridation



improvement (circuit rider); provided \$50,000 to improve fluoridation in Alaska (bought in line fluoridation monitors and improved quality control); helped with accreditation of the IHS Residency Program; provided DOH speakers at conferences; and was represented from 2004-2008 on the IHS National Health Promotion / Disease Prevention Committee.

In terms of the results that DOH has found nationwide among AI/AN children, they have found that children 4 to 5 and 6 to 11 years of age from non-fluoridated villages had 3 times and 1.5 times the number of dental caries in primary teeth than children from fluoridated villages, respectively. Children 6 to 11 and 12 to 15 years of age from non-fluoridated villages had twice the number of dental caries in permanent teeth as children from fluoridated villages. The frustrating thing is that most dental caries are completely preventable from primary prevention mechanisms, so if they can just do a better job of getting information about self-care, fluoridation, and sealants, in a generation a significant amount of tooth decay could be eliminated. Some people do not trust fluoridation, so this can be problematic. As an aside, Dr. Kohn noted that January 25, 2010 was the 65<sup>th</sup> anniversary of community water fluoridation in the US. It began in Grand Rapids, Michigan on January 25, 1945. Since that time, there have been many studies and expert reviews about the safety of the safety and effectiveness of fluoridation.

Opportunities include surveillance consultation and inclusion of tribal disease data on the National Oral Health Surveillance System (NOHSS) and telling success stories; assistance with remote monitoring of fluoridated water systems; and quality assurance monitoring of tribal water systems through the CDC Water Fluoridation Reporting System (WFRS). DOH received some addition funding this year and will soon publish and FOA for four more state infrastructure grants. These will be advertised to tribal organizations, which will be eligible for cooperative agreements to help build infrastructure. This is an opportunity to have someone with a sole focus on administrating the program, collecting data, managing the quality of fluoridation and sealant programs, et cetera.

### **Discussion Points**

- Mr. Franklin inquired as to when the FOA would be published.
- Dr. Kohn replied that this would be in the coming cycle, for which the budget process is just now unfolding.
- Ms. Hughes noted that dental care is second or third in the list of priorities in Indian Country. Need is great. There are fluoridation and sealant programs, but because the inconsistency of being able to provide service, the problem that has been created over the years is still not being dealt with. By the time youth are in high school, they have dental problems that should have been corrected sooner. The waiting list to get in to dental clinics is extremely long.
- Ms. Sebattus indicated that USET has a dental support center. When they were seeking more data on dental health at the tribal level, the most recent data they were able to find was from 1999. There have not been funds to duplicate this survey that was Indian Countrywide. For the national area tribes, USET conducted a similar survey and used similar parameters that the state used to obtain data for tribes. It would be beneficial to duplicate this throughout Indian Country.



- Dr. Kohn noted that one of the requirements of the cooperative agreement that will be published is the collection of data at least every five years. DOH can also provide technical assistance. Dental surveys can be very resource-intensive because there is so much data. DOH develop a basic screening survey for children, which is a much simpler surveillance tool: decay / no decay; untreated / treated; et cetera. DOH can provide this assistance even to those who are not funded.
- Mr. Franklin complimented Dr. Giles and his staff for the very respectful tone they were using in their presentations. He liked what was said earlier about shifting from “awfulizing” to action. He also noted that the information being presented could actually fill an entire day, and that he would like them to consider presenting at the NIHB conference in May 2010 in Albuquerque and perhaps the annual consumer conference. While this is good information for TCAC members to hear because they will take it back to their communities, tribal leaders will want to hear this discussion as well. Moreover, they will offer awesome input.

### **Division of Nutrition, Physical Activity, & Obesity**

**Rosanne Farris, PhD**

**Program Development and Evaluation Branch Chief**

**Division of Nutrition, Physical Activity, & Obesity (DNPAO)**

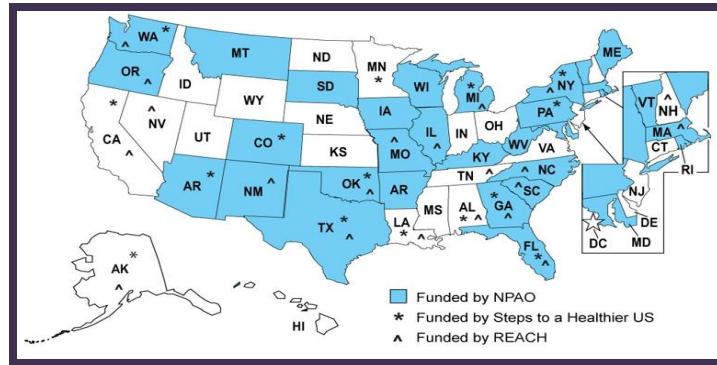
**National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)**

**Centers for Disease Control and Prevention (CDC)**

Dr. Farris reported that obesity continues to be a major problem in the US, with one third of adults obese and 16% of children ages 2 to 19 obese. To address this issue, the vision of DNPAO is “A world where regular physical activity, good nutrition, and healthy weight are part of everyone's life” and its mission is to, “Lead strategic public health efforts to prevent and control obesity, chronic disease, and other health conditions through regular physical activity and good nutrition.” The goals of DNPAO are to increase health-related physical activity through population-based approaches; improve dietary quality most related to population burden of chronic disease and unhealthy child development; and decrease prevalence of obesity through prevention of excess weight gain and maintenance of healthy weight loss.

State programs need to develop strategies to leverage resources and coordinate statewide efforts with multiple partners to address all of the following DNPAO principal target areas. CDC sees these six target behaviors as key to preventing and reducing the prevalence of obesity: increase breastfeeding initiation, duration, and exclusivity; increase physical activity; increase consumption of fruits and vegetables; decrease consumption of sugar sweetened beverages; reduce consumption of high energy dense foods; and decrease television viewing.

Congress provided specific funding to CDC to address the public health problem of obesity starting in 1999. Six programs were funded in the first year and grew in numbers over the years. As illustrated on the following map, DNPAO currently funds 25 states (shown in blue) for its nutrition, physical activity, and obesity prevention state program. In addition, all states and territories will receive funding in January 2010 for two-year recovery act funds for policy and environmental initiatives related to nutrition, physical activity, and tobacco prevention:



Several programs are on-going in Montana, including the following:

- Blackfeet Tribe has a program with a focus on breastfeeding (Destiny Anderson of Indian Health Service will assist with this effort)
- Ft. Belknap has a program with a focus on physical activity in Head Start (the Fort Belknap Indian Reservation is the homeland of the Gros Ventre and Assiniboine people)
- Rocky Boy has a program with a focus on physical activity in the Boys and Girls Club (the Rocky Boy Reservation is homeland of the Chippewa and Cree)
- Flathead has a program with a focus on physical activity and some nutrition in its after school program (the Flathead Reservation is the homeland of the Confederated Salish and Kootenai Tribes)

Cathy Edgerly, a Program Specialist, is working for the Inter-tribal Council of Michigan. She represents the Council and works on the Healthy Weight Partnership and State Planning Group. The tribes working with Inter-Tribal Council of Michigan include the following:

- Bay Mills Indian Community (Sault ste. Marie Tribe of Ojibwe)
- Grand Traverse Band of Ottawa and Chippewa Indians
- Hannahville Indian Community (Potawatomi)
- Keweenaw Bay Indian Community (Ojibwe)
- Lac Vieux Desert Band of Lake Superior Chippewa Indians
- Little Traverse Bay Bands of Odawa Indians
- Match-E-Be-Bash-She (Gun Lake Tribe, Potawatomi)
- Nottawaseppi Band of Huron Potawatomi
- Pokagan Band of Potawatomi Indians
- Saginaw Chippewa Indian Tribe





Three pueblos in New Mexico (Pueblo of Cochit, Pueblo of Santa Clara and Pueblo of San Ildefonso ) are working on obesity plans.

There is quite a lot going with the Ojibwe and Chippewa tribes in Minnesota. They are in the planning stages of a breastfeeding supports and challenges assessment. They are conducting focus groups with several priority populations, including Native American Indians, to learn more about needs and ways to approach increasing breastfeeding rates. The following reservations are involved in this effort:

- Leech Lake Reservation (Ojibwe)
- Grand Portage Reservation (Ojibwe)
- Bois Forte Reservation (Ojibwe)
- Fond du Lac Reservation (Ojibwe)
- Mille Lacs Reservation (Ojibwe)
- Red Lake Comprehensive Health Services
- White Earth Reservation (Ojibwe)

DNPAO funds the states' breastfeeding teleconferences. DNPAO-Breastfeeding Work Group partners with the United States Breastfeeding Committee to provide training and opportunities for networking for coalition members. The teleconferences also provide an opportunity for interactions and discussion on a wide variety of topics related to breastfeeding support. A topic covered during one of the teleconferences was breastfeeding legislation.

The Navajo Nation Breastfeeding Coalition members worked diligently to pass the pivotal Healthy Start Act in 2008. This Act requires Navajo Reservation employers to provide: 1) a flexible work schedule for breastfeeding or milk expression, 2) a private room for breastfeeding or breast pump usage for milk expression.

There are a number of opportunities to continue to work together. One is to increase the number of health promotion program examples in AI/AN communities to show case (limited examples exist in the literature now). This will serve as an example for other tribes to use and learn from. There are also opportunities for AI/AN communities to tailor interventions to their specific culture and health priorities. The program characteristics include culturally competent and community-driven approach to decrease obesity and chronic disease such as diabetes. There is very little work in health promotion programs that involves AI/AN communities. Through support and technical assistance, Indian Tribal Organizations can learn to assess, develop plans, locate resources, ensure ways to measure progress, use data, and complete program evaluation. The process will also enhance their capacity to work on other community health concerns or issues. Capacity to work on obesity is limited.

For more information regarding DNPAO resources, contact information is as follows:

Claire Heiser, DNPAO Program Team Lead, 770-488-5284  
Lorraine Whitehair, Public Health Nutritionist 770-488-5704  
<http://www.cdc.gov/obesity/stateprograms/index.html>



**Office On Smoking and Health**

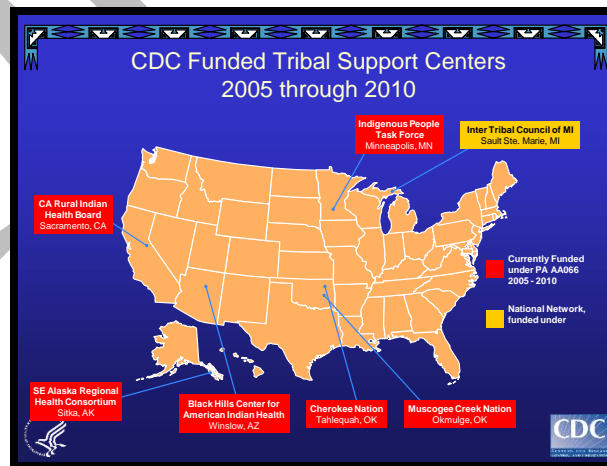
**Dianne May, PhD  
Program Services Branch (PSB)  
Office On Smoking and Health (OSH)  
National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)  
Centers for Disease Control and Prevention (CDC)**

Dr. May indicated that the mission of OHS is as follows, “As the lead federal agency for comprehensive tobacco prevention and control, OSH develops, conducts, and supports strategic efforts to protect the public’s health from the harmful effects of tobacco use.” OSH’s goals are to prevent initiation, promote cessation, eliminate secondhand smoke exposure, and identify and eliminate tobacco-related disparities.

OSH currently funds 50 states and DC, 8 Territories, 6 National Networks, and 6 Tribal Support Centers. OHS has an MOU with Indian Health Service which is approximately \$75,000 per year to fund staff activities. These activities include providing data analysis on American Indian Adult Tobacco Survey (AI ATS); developing tribal funding recommendations; and conducting strategic planning.

The American Indian / Alaska Native National Network is in year 2 of a 5-year cooperative agreement at about \$400,000 per year that is allocated to the Inter-Tribal Council of Michigan, which is the lead. National network activities include training and technical assistance for tribes and tribal organizations on implementing the AI ATS, analyzing and using AI ATS data, planning communications and media, developing policy; and convening a national advisory board. When a tribe conducts the AI ATS, the tribe owns the data.

Tribal Support Centers are in year 5 of a cooperative agreement, with a new cooperative agreement announcement to be funded at some point. There are 6 funded grantees and 7 cooperative agreements of about \$1.6 million per year. The centers are shown on the following map:





The purpose of the Tribal Support Centers includes: 1) capacity-building programs lead tribal efforts to reduce abuse of commercial tobacco and secondhand smoke exposure; and 2) implementation programs to implement and evaluate tobacco control strategies. Capacity-building is being done with the Black Hills Center for American Indian Health, California Rural Indian Health Board, Cherokee Nation, and Indigenous Peoples' Task Force. Implementation is being done with California Rural Indian Health Board, Muscogee (Creek) Nation, and Southeast Alaska Regional Health Consortium.

There are a number of Tribal Support Center activities. Tribes working with Tribal Support Centers tend to have higher tobacco taxes than other tribes. In some instances, the tribal taxes are higher than state taxes. As a result of Tribal Support Center work, several tribes are working with states to measure secondhand smoke levels in tribal casinos. Several of the tribes in Oklahoma are working with the Oklahoma Department of Health and the University of Oklahoma to measure second hand smoke levels in the casinos. Muscogee Creek Nation penalties are more stringent than the State of Oklahoma's for selling commercial tobacco products to minors. Tribal Support Centers are also using findings from the AI ATS to develop culturally appropriate interventions. Tribal Support Centers and the National Native Commercial Tobacco Abuse Prevention Network (NNCTAPN) are working with Legacy, RWJF, and other partners to expand surveillance systems and implement culturally appropriate interventions and evaluations. Muscogee Creek Nation, Cherokee Nation (which just completed the AI ATS), CRIHB, the former Tribal Support Center Intertribal Council of Michigan all have developed commercial tobacco abuse interventions that were informed by AI ATS findings. CDC's national partners have funded several projects for the Tribal Support Centers in the areas of surveillance systems and culturally appropriate interventions and evaluations. Tribal Support Centers are working with the NNCTAPN on a REACH-US initiative that seeks to integrate tobacco control with chronic disease programs in tribal health systems. Tribal Support Centers and the NNCTAPN are working with local governments in areas with large AI/AN populations to adopt no commercial tobacco policies and smoke-free work policies.

### **Discussion Points**

Mr. Petherick pointed out that the tobacco and health sides needed to be balanced. He expressed hope that this would be communicated in the activities being undertaken, especially working with states and local governments that do not always understand the tribal side. Tribes were put in a situation where they had a zero economic base and had to develop an economy. Unfortunately, tobacco issues have always been a part of that. They always say, "We want you to buy tobacco. Just don't use it."

### **Division of Adult and Community Health**

**Lynda Anderson, PhD, Acting Director**  
**Division of Adult and Community Health (DACH)**  
**National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)**  
**Centers for Disease Control and Prevention (CDC)**

Dr. Anderson reported that DACH is charged with providing cross-cutting chronic disease and health promotion expertise and support to CDC's NCCDPHP as well as to states, communities,

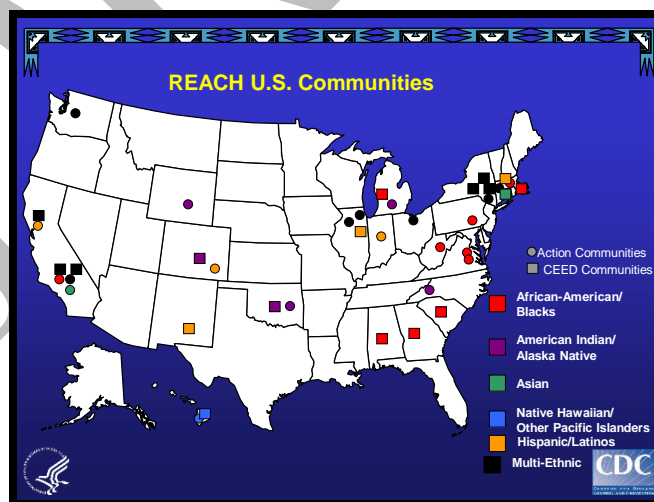


and other partners. DACH also manages several important chronic disease prevention and control programs for specific chronic diseases, assesses new and emerging chronic disease issues, and launches new programs for NCCDPHP. DACH spending on activities that target AI/AN populations is \$4,908,199.

In terms of centerwide services, several programs within DACH serve as bases for delivering epidemiologic support, prevention research, and flexible program funding in states that support all of NCCDPHP’s programs. These programs include the Prevention Research Centers (PRCs) and the Preventive Health and Health Services Block Grant. With respect to cross-cutting approaches, DACH manages several programs that address an array of issues related to chronic disease prevention and health promotion for specific populations. The division also provides expertise and national leadership in health education and promotion, both of which are tools widely used in chronic disease prevention efforts. Such efforts include Healthy Aging, Healthy Communities Program, Health-Related Quality of Life, and REACH.

Regarding emerging issues, DACH is also charged with undertaking innovative scientific research on emerging and cross-cutting chronic disease and health promotion issues for CDC. These research initiatives define the extent and public health impact of emerging issues and develop the scientific basis for public health solutions. These programs include ACE, Alcohol, Alzheimer’s, Mental Health and Social Determinants of Health. DACH launches new and growing programs for NCCDPHP, some of which have historically become separate divisions as they have matured. Major chronic disease programs and initiatives currently being launched by DACH are Arthritis and Epilepsy.

DACH’s REACH US program funds 40 communities throughout the country to advance the prevention and elimination of health disparities among racial and ethnic minority groups, and to understand and spread successful strategies for achieving significant changes at the community level. Forty REACH US Communities include 18 Centers of Excellence in the Elimination of Health Disparities (CEEDs) and 22 Action Communities. CEEDs have expertise in working with specific ethnic groups and widely disseminating effective strategies. The REACH US Communities are depicted in the following map:



Under the REACH US program, CDC awarded 6 entities targeting the elimination of health disparities in American Indian communities. All six are fully engaged in intervention activities.



Two of these entities, Oklahoma State Department of Public Health and the University of Colorado at Denver and Health Sciences Center, are functioning as CEEDs and serving as resource centers on effective interventions in addition to working in their home communities. Oklahoma State Department of Public Health–Southern Plains REACH US (SPRUS) has chosen to work with American Indian Tribal Communities in the Southern Plains Region (e.g., Oklahoma, Texas, and Kansas) to reduce the risk of diabetes and CVD through activities related to nutrition, physical activity, and tobacco control prevention. Current funding totals \$844,284. The University of Colorado at Denver and Health Sciences Center works to reduce CVD risk among urban American Indians through community and clinically based interventions. Current funding totals \$738,938.

Four entities (e.g., Choctaw Nation of Oklahoma, Eastern Band of Cherokee Indians, Inter-Tribal Council of Michigan, and Northern Arapaho Tribe) are funded as Action communities. They are implementing and evaluating successful approaches with specific communities that impact AI/AN populations. The Choctaw Nation of Oklahoma received a Core Capacity Building under the REACH 2010 program. After successfully building their capacity and infrastructure, they are now implementing their Lifetime Legacy Project with REACH US. The project focuses on healthy priority area of cardiovascular disease as well as the intervening variables of childhood obesity, tobacco and substance abuse, specifically methamphetamine use. The Eastern Band of Cherokee Indians (EBCI) works to reduce the risk for Type 2 Diabetes in the EBCI communities by promoting physical, emotional, and cultural well being. The Inter-Tribal Council of Michigan continues to implement community-based intervention activities to reduce cardiovascular disease and diabetes related disparities that are culturally tailored to each of three tribal communities, while providing overall technical assistance to the tribes and disseminating results of the culturally tailored interventions among consortium partners. The Northern Arapaho Tribe Wind River Indian Reservation (WRIR) plans to reduce the rate of infant mortality among American Indians on the WRIR through community based approaches. These approaches include increasing community awareness and commitment to eliminating infant mortality disparities through coordinated and multi-organizational action.

Current funding for these four entities is as follows:

- Choctaw Nation of Oklahoma \$415,390
- Eastern Band of Cherokee \$415,390
- Inter-Tribal Council of Michigan \$415,390
- Northern Arapaho \$398,807

The Healthy Communities Program began in 2003, and was formerly the Steps Program. To date, more than 200 communities have received funding and technical support to mobilize communities with a focus on Diabetes, Heart Disease, and Obesity Prevention; and Physical Activity, Nutrition, Tobacco Use Prevention. This program directly funds and supports communities through city health departments, and rural local health departments through states, tribes, and community organizations with national reach.

The Sault Saint Marie Tribe of Chippewa Indians and the Cherokee Nation are entering into the second year of a five-year cooperative agreement to develop and implement policy, systems, and environmental changes addressing chronic disease risk factors of physical inactivity, poor eating and nutrition, and tobacco use and exposure to reduce the burden of chronic diseases such as obesity, diabetes, cardiovascular disease. Four communities from the Sault Saint Marie Tribe are participating in this initiative: Sault Saint Marie, St. Ignace, Manistique, and



Munising. Four counties across the Cherokee Nation are participating as well: Cherokee County, Mayes County, Sequoyah County, and Adair County. Each tribe receives \$400,000.

The PRCs are a national network of 35 academic research centers that conduct community-based participatory research (CBPR) and partner with communities, health care providers, and state and local public health agencies. Centers that target AI/AN populations, with current funding for 2009 of \$790,000 per center, include the following:

- ❑ Oregon Health and Science University, Center for Healthy Native Communities evaluated onsite eye exams and telemedicine to diagnose and treat diabetes-related eye disease and vision problems among American Indians in the Pacific Northwest. This center was approved and funded for the 2010-2014 program cycle and will create a hearing loss prevention program for American Indians and Alaska natives.
- ❑ University of New Mexico, Center for Health Promotion and Disease Prevention tested the effectiveness of school- and community-based interventions for identifying and reducing psychological distress among American Indian youth who witness or experience violence. This program is called Teen Health Resiliency Intervention for Violence Exposure (THRIVE). Data are being evaluated to determine the successfulness of increasing participants' coping skills, reducing the symptoms of trauma, and of maintaining positive effects over time. The center has been approved and funded for the 2010-2014 program cycle.

The American Recovery and Reinvestment Act (ARRA) Communities Putting Prevention to Work (CPPW) grants total \$450 million, which includes \$373 million FOA, evaluation, and community support. The goal of the CPPW grants is to reduce risk factors and prevent / delay chronic disease and promote wellness in both children and adults at the local level via cities, states, and tribes. Addressing risk factors includes reducing obesity through improved nutrition and physical activity; and reducing tobacco use. Interventions include policy and environmental change at the local level through evidence-based strategies in the areas of media, access, point of decision, price, and social support. Objective reviews took place January 11-15, 2010 and awards are expected to be made soon for a two-year funding period.

### **Discussion Points**

- Mr. Gilbert inquired as to whether the two PRCs mentioned were the only two funded, or were the only two with an AI/AN focus.
- Dr. Anderson clarified that there are 35 PRCs throughout the country. The two she mentioned focus their core research specifically on tribal issues.
- Mr. Gilbert said they believe they have good capacity at the Alaska Native Medical Center (ANMC) to conduct research that is tribally owned and driven. They interact with CDC on different levels, and as they went through the list, he could think of three or four projects that they have with DCPC, OSH, and a couple of others. ANMC feels that they have a good handle on their basic data and regard themselves as a health system somewhat like Kaiser, with cradle-to-grave care and access to data at different points in people's lives. Over the last couple of years, they have thought about the value of having a PRC to translate what they have into evidence-based action. With that in mind, he wondered whether there would be opportunities to establish PRCs in the future, and if so, whether tribal programs would be eligible instead of universities as the applicants of those grants.



- Dr. Anderson responded that the way this was set up, certain entities are eligible for the core infrastructure, but there are opportunities for collaborations with already funded PRCs through special interest projects. The division would be happy to inform ANMC where those may be located nearby to help make some linkages to existing PRCs, and to discuss other opportunities as well.
- Mr. Gilbert indicated that some of those present had successes with the NARCH programs. This is not exactly full tribal ownership of research, but it leans toward that and requires a partnership with an academic institution. However, it is a two-way street and is not necessarily academia coming to his backyard with an idea. Speaking for Alaska, he loved the idea of PRCs that are more tribally owned and operated.
- Dr. Giles responded that something unique about the PRCs was the link between what is occurring in the community and what is occurring in the academic centers. All of them have a Community Advisory Board (CAB), which drives the research and specifies the topics they believe are important to address in the community. The PRCs were recently competed, which is done on a five-year cycle. Thus, it will be several years before the next round. However, there may other opportunities through other mechanisms such as REACH or special interest project.

DRAFT



## **Division of Diabetes Translation**

**Dawn Satterfield RN PhD**

**Native Diabetes Wellness Program (Team Lead)**

**Division of Diabetes Translation (DDT)**

**National Center for Chronic Disease Prevention & Health Promotion (NCCDPHP)**

**Centers for Disease Control and Prevention (CDC)**

Dr. Satterfield indicated that DDT's vision is "A world free of the devastation of diabetes" and that its mission is "To reduce the preventable burden of diabetes through public health leadership, partnerships, research, programs and policies that translate science into practice. The division's goals are to prevent diabetes; prevent complications, disabilities, and burden related to diabetes; eliminate diabetes-related health disparities; eliminate disparities, which are starkly revealed by diabetes in Indian Country.

In the past decade basically, 1995 to 2004, trends in diabetes increased in both US and American Indian and Alaska Native populations. However, in 2004, the age-adjusted prevalence of diagnosed diabetes among AI/AN adults was 2.5 times that of US Whites (16.3% versus 6.5%). Throughout the period, prevalence in the AI/AN population was more than 2 times that of Whites [Source: 1995–2005 IHS user population data and National Diabetes Surveillance System]. Dr. Pyone Cho is working on data to determine the actual number and rates of children across the country who are developing Type 1 and Type 2 diabetes.

In the face of this stark reality that many tribal leaders know only too well, DDT epidemiologists have encouraging trends to report. End state renal disease related to diabetes decreased in all race / ethnicity groups with the exception of Hispanics. American Indians and Alaska Natives had the most dramatic drop, which is cause to celebrate, as the IHS Diabetes Program has pointed out. The hard work of tribal communities, with the support of the SDPI, has surely been a major reason and should be honored.

With a 2010 appropriation of \$66 million, DDT strives to identify trends in diabetes incidence, prevalence, and mortality; and translate science to action by communicating evidence-based prevention messages and implementing effective public health programs. The *Move It!* campaign is a national diabetes education program that was developed with the American Indian and Alaska Native Work Group of the National Diabetes Education Program and the American Association of Indian Physicians. More recently, they have had the good news that diabetes often can be prevented with modest weight lost, attention to healthy foods, and physical activity. In addition, 171 American Indians contributed to the landmark study that now allows them to say to the world that diabetes can very often be prevented with these types of activities and nutrition. DDT also implements effective public health programs. All 50 states and 9 territories have diabetes programs. The Native Diabetes Program works with the 6 US-associated Pacific Islands as well.





DDT specifically turned their attention to American Indian / Alaska Native disparities in diabetes to address those with communities, and with grounding principles of social justice with respect for both Native and Western science. They dream every day of a life of balance, a community of support, a program of prevention, and a message of hope. The goals of the Native Diabetes Wellness Program are to support sustainable ecological approaches to restore traditional foods and activities in communities; share messages about traditional ways of health that are remembered, retold, and talked about in homes, schools, and communities; and support meaningful tribal consultation at state and federal levels.

Dr. Satterfield highlighted some examples of support to restore traditional foods and share messages of traditional ways of health. Since 2001, the National Institutes of Health, NIDDK, in partnership with the Tribal Leaders Diabetes Committee, CDC Native Diabetes Wellness Program, the Indian Health Service Division of Diabetes Treatment and Prevention, and eight tribal colleges and universities (TCUs), have developed the K-12 science- and culturally-based *Health is Life in Balance Diabetes Education in Tribal Schools (DETS)* curriculum. Originally, 11 programs were funded. Based on the Tribal Diabetes Leaders Committee report that they could have the \$1 million more for 2010 / 2010, and the division's support, an additional 6 programs were funded. Samples of the curriculum were placed on the information tables outside the conference room. The eight TCUs are: Cankdeska Cikana Community College (Fort Totten, ND), Fort Peck Community College (Poplar, MT), Haskell Indian Nations University (Lawrence, KS), Keweenaw Bay Ojibwa Community College (Baraga, MI), Leech Lake Tribal College (Cass Lake, MN), Northwest Indian College (Bellingham, WA), Stone Child College (Box Elder, MT), and Southwestern Indian Polytechnic Institute (Albuquerque, NM).

All partners worked with school sites throughout the US to test the curriculum in three evaluation phases. Sister sites were also included in the last evaluation phase to include parts of the country not originally in the eight TCUs areas. In addition to funding, CDC assisted with the DETS evaluation format and scientific oversight for the project. The Eagle Books are included as part of the K-4 lessons plans. The curriculum was rolled out in November 2008 at the Smithsonian National Museum of the American Indian in Washington, DC. The roll out coincided with the Eagle Books original watercolor art exhibit at the same locale. From FY 2009-2011, all partners are providing education outreach and teacher development training in all states that have AI/AN populations. NDWP is leading a DETS impact evaluation case study in four communities each year through 2012. These case studies are to provide community-specific information on the DETS curriculum use and acceptance as well as the impact of the Eagle Books in classroom and community. These materials are available to tribes in any amount they would like. They also have the potential to make templates available to tribes through DETS for those who want to translate the books into their own languages. Several versions already exist, and they recently heard that Creek Nation is interested in developing a translation.

For the Traditional Foods project, 11 grantees were originally funded at \$100,000 each. The good news is that due to the Tribal Diabetes Leaders Committee recommendations to Congress for the program to receive \$1 million through 2011, DDT continued to receive support from IHS. As a result, DDT was able to fund 6 more grantees. The following map depicts the funded sites:



To date, *Indian Country Today* has published three articles about this project. One of the articles featured the Standing Rock Diabetes Program: Native Gardens Project, which has had some early success in just the year that they have been able to incorporate this project into what they already had underway. They partnered with USDA's Nutrition Program for Seniors, and now have vouchers that are going to elders. These have been cashed in at a rate of 50% just in the first year (e.g., \$17,000 worth of local foods have been cashed in). They also have three functional farmer's markets.

DDT grantees meet twice a year. Their second grantee meeting was convened in November 2009 in Albuquerque. Rewarding words are heard from the grantees. For example, Tammi Meissner of the Southeast Alaska Health Care Consortium said, *This program is so important because in addition to traditions being kept alive, "we" are reclaiming the sense of community...* These are the things that keep them going on the rough days. DDT is also mapping out their schedule for the coming years, and wondered whether there might be an interest in coinciding their 2011 meeting with TCAC's Atlanta meeting.


**CDC Budget and AI / AN Resource Allocations**

**Mr. Robert Curlee, Deputy Director  
Financial Management Office (FMO)  
Centers for Disease Control and Prevention (CDC)**

Mr. Curlee showed several tables representing CDC / ATSDR resources committed to programs that benefit American Indian / Alaska Native (AI/AN) populations and communities from 2009 compared to 2008. Fiscal information was summarized in the data presented according to organizational and disease-specific programs, and by defined funding allocation categories. Recovery act funding was not included in this information, nor had 2010 information been prepared at this time, although Mr. Curlee noted that there are some efforts underway.



Total CDC / ATSDR funding with VFC (73%) is \$168,275,464. Total funding without the VFC is \$46,009,312 (27%). Excluding ATSDR, total funding with VFC is \$167,637,959 and without is \$45,371,807. Funding resources aligned with coordinating centers is reflected in the following table:

		
Funding Resources Aligned with Coordinating Center Center/Institute/Office (CC/CIO)	Total Funding FY2009 w/ VFC	Total Funding FY2009 w/o VFC
<b>Coordinating Center for Infectious Diseases</b>	<b>\$129,574,394</b>	<b>\$7,308,242</b>
NCVZED	\$106,000	\$106,000
NCHHSTP	\$3,542,458	\$3,542,458
NCIRD	\$45,371,807	
	\$122,605,845	\$339,693
NCPDCID	\$3,320,091	\$3,320,091
<b>Coordinating Center for Health Promotion</b>	<b>\$27,568,187</b>	<b>\$27,568,187</b>
NCBDDD	\$200,000	\$200,000
NCCDPHP	\$27,368,187	\$27,368,187
<b>Coordinating Center for Health Information and Service</b>	<b>\$1,665,361</b>	<b>\$1,665,361</b>
NCHS	\$1,665,361	\$1,665,361
<b>Coordinating Center for Environmental Health and Injury Prevention</b>	<b>\$2,240,561</b>	<b>\$2,240,561</b>
NCEH	\$788,371	\$788,371
NCIPC	\$1,452,190	\$1,452,190
<b>National Institute for Occupational Safety and Health</b>	<b>\$322,140</b>	<b>\$322,140</b>
<b>Coordinating Office for Terrorism Preparedness &amp; Emergency Response</b>	<b>\$4,651,716</b>	<b>\$4,651,716</b>
<b>Office of the Director</b>	<b>\$1,615,600</b>	<b>\$1,615,600</b>
OWCD	\$496,079	\$496,079
OMHD/OD	\$1,119,521	\$1,119,521
<b>CDC-CC/CIO Grand Total</b>	<b>\$167,637,959</b>	<b>\$45,371,807</b>
<b>ATSDR Total</b>	<b>\$637,505</b>	<b>\$637,505</b>
<b>CDC/ATSDR Grand Total</b>	<b>\$168,275,464</b>	<b>\$46,009,312</b>

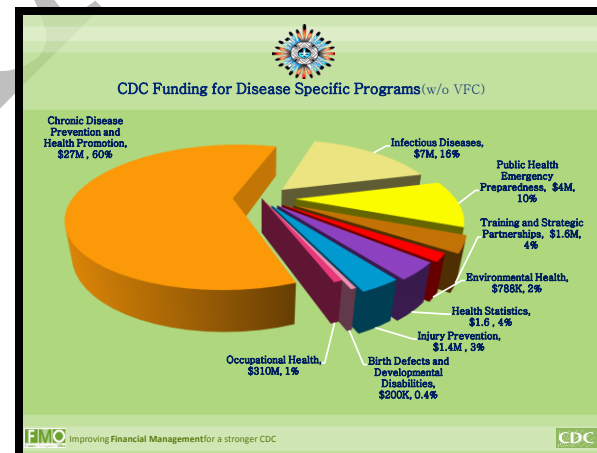
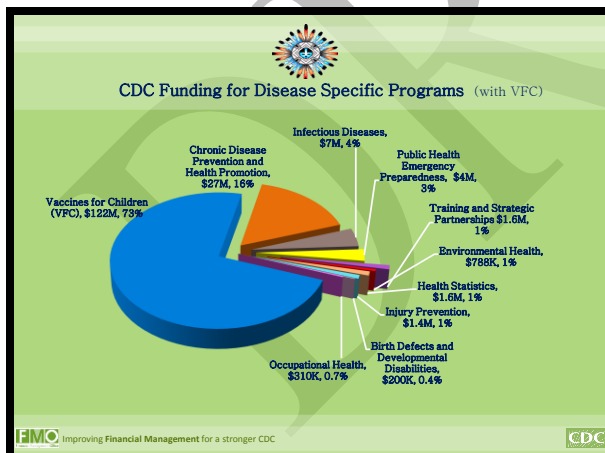
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Funding resources aligned with disease specific programs (with ATSDR) are shown in the following table:

CDC Funding Resources Aligned with Disease Specific Programs (with ATSDR): A Comparison	FUNDING LEVEL FY 2008	FUNDING LEVEL FY 2009	Percent of Change
<b>Chronic Disease Prevention and Health Promotion</b>	<b>\$ 25,884,960</b>	<b>\$ 27,286,210</b>	<b>5%</b>
Cancer	\$11,502,097	\$14,077,332	22%
Cross-cutting Programs	\$7,178,202	\$5,613,762	-22%
Diabetes	\$3,349,585	\$4,039,402	21%
Tobacco	\$2,162,395	\$2,064,618	-5%
Heart Disease and Stroke Prevention	\$1,010,000	\$975,000	-3%
Maternal Child Health	\$292,584	\$147,749	-50%
Adolescent and School Health	\$390,097	\$368,347	-6%
<b>Infectious Diseases</b>	<b>\$ 7,715,374</b>	<b>\$ 7,390,219</b>	<b>-4%</b>
Infectious Disease Prevention (new category for FY 09)	N/A	\$46,000	N/A
Infectious Diseases in Alaska Natives	\$2,631,565	\$3,380,091	28%
HIV/AIDS	\$3,194,827	\$2,493,544	-22%
STDs	\$1,117,005	\$898,891	-20%
Vaccine-preventable diseases (non-VFC funds)	\$321,477	\$399,693	6%
Viral Hepatitis (not reported for 09)	\$217,000	\$232,000	7%
Other	\$234,000	\$0	-100%
<b>Public Health Emergency Preparedness</b>	<b>\$ 5,192,034</b>	<b>\$ 4,651,716</b>	<b>-10%</b>
<b>Public Health Capacity, Strategic Partnerships and Training (OD)</b>	<b>\$ 1,612,545</b>	<b>\$ 1,627,600</b>	<b>1%</b>
<b>Environmental Health</b>	<b>\$ 614,686</b>	<b>\$ 788,371</b>	<b>28%</b>
Environmental Public Health Services/Research	\$614,686	\$788,371	28%
<b>Health Statistics</b>	<b>\$ 1,424,746</b>	<b>\$ 1,665,361</b>	<b>17%</b>
<b>Injury Prevention</b>	<b>\$ 581,920</b>	<b>\$ 1,452,190</b>	<b>150%</b>
Unintentional Injuries	\$435,920	\$150,000	-66%
Violence Prevention	\$146,000	\$1,302,190	792%
<b>Birth Defects/Developmental Disabilities</b>	<b>\$ 250,000</b>	<b>\$ 200,000</b>	<b>-20%</b>
<b>Occupational Health</b>	<b>\$ 310,140</b>	<b>\$ 310,140</b>	<b>0%</b>
<b>Health Marketing</b>	<b>\$ 229,000</b>	<b>\$ -</b>	<b>-100%</b>
<b>CDC Total w/o VFC</b>	<b>\$ 43,815,405</b>	<b>\$ 45,371,807</b>	<b>4%</b>
<b>Vaccines for Children</b>	<b>\$ 64,263,901</b>	<b>\$ 122,266,152</b>	<b>90%</b>
<b>CDC Total with VFC</b>	<b>\$108,079,306</b>	<b>\$167,637,959</b>	<b>55%</b>
<b>ATSDR Improving Financial Management for a stronger CDC</b>	<b>\$ 682,470</b>	<b>\$ 637,505</b>	<b>-7%</b>

Funding for disease-specific programs with VFC and without VFC is illustrated in the following pie charts:





Funding allocation categories include the following:

**AI/AN Awardees (Direct)**

Competitively awarded programs (i.e., grants, cooperative agreements) where the awardee is a tribe / tribal government, tribal organization, tribal epidemiology, Alaska Native organization, tribal college, tribal university, or urban Indian Health program.

**Intramural AI/AN**

Intramural programs, the purpose of which is to primarily or substantially benefit AI/AN.\*

*\*This category would include costs (e.g., salary, fringe, travel, et cetera) associated with CDC staff or contractors whose time / effort primarily or substantially (50% or better) benefit AI/AN.*

**Extramural AI/AN Benefit**

Competitively awarded programs for which the purpose of the award is to primarily or substantially benefit AI/AN.

**Federal AI/AN Benefit**

Federal Intra-Agency Agreements wherein the purpose of the agreement is to primarily or substantially benefit AI/AN.

**Indirect AI/AN**

Service programs for which funding for AIs / ANs can reasonably be estimated from available data on the number of AIs / ANs served\*\*

*\*\*This category applies only to the Vaccines for Children program and to NCHS.*

In comparison to 2008, 2009 indirect AI/AN awards (with VFC) increased from \$65 million to \$123 million. Funding allocation categories aligned with disease-specific programs (with VFC) and a comparison of allocation categories for fiscal years 2008 and 2009 are reflected in the following tables:



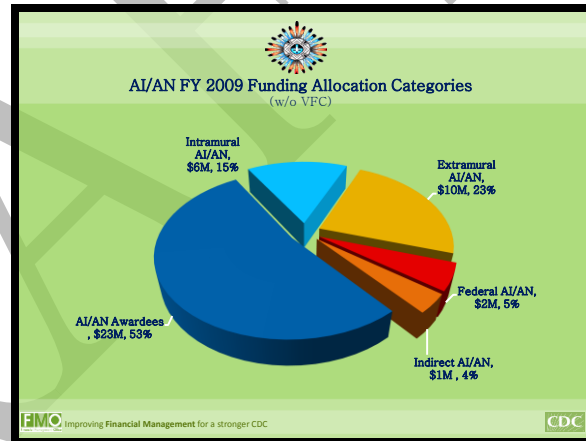
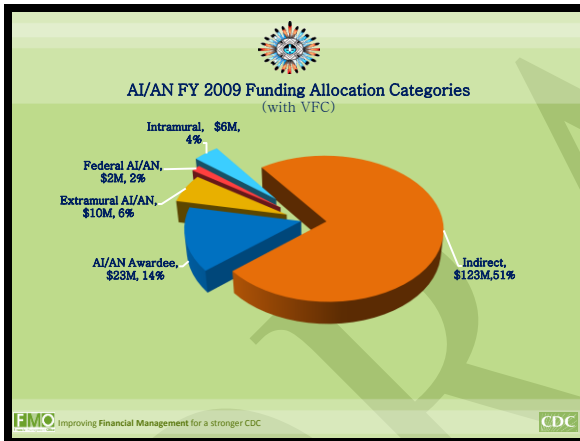
**CDC Funding Allocation Categories Aligned with Disease Specific Programs (with VFC)**

Disease Specific Programs	AI/AN Awardees	Intramural AI/AN	Extramural AI/AN	Federal AI/AN	Indirect AI/AN
Vaccines for Children (VFC)					\$122,266,152
Chronic Disease Prevention and Health Promotion	\$20,590,186	\$1,166,791	\$3,931,499	\$1,679,711	
Infectious Diseases	\$2,295,195	\$3,993,353	\$485,000	\$534,694	
Public Health Emergency Preparedness			\$4,651,716		
Training and Strategic Partnerships (OD)	\$596,905	\$878,585	\$124,140	\$27,970	
Environmental Health Health Statistics	\$230,209	\$552,270		\$5,892	\$1,665,361
Injury Prevention Birth Defects and Developmental Disabilities	\$141,717	\$200,000	\$1,160,473	\$150,000	
Occupational Health			\$310,140		
<b>CDC Funding Allocation Categories - Grand Totals</b>	<b>\$23,854,212</b>	<b>\$6,790,999</b>	<b>\$10,862,968</b>	<b>\$2,398,267</b>	<b>\$123,931,513</b>

**CDC Funding Allocation Categories for FY 2008 and FY 2009**

Funding Allocation Category	With VFC		Percent Change	Without VFC		Percent Change
	FY 2008	FY 2009		FY 2008	FY 2009	
AI/AN Awardees	\$22,839,514	\$23,854,212	4%	\$22,839,514	\$23,854,212	4%
Intramural AI/AN	\$6,856,724	\$6,790,999	-1%	\$6,856,724	\$6,790,999	-1%
Extramural AI/AN	\$10,687,986	\$10,662,968	-0.20%	\$10,687,986	\$10,662,968	-0.20%
Federal AI/AN	\$2,006,435	\$2,398,267	20%	\$2,006,435	\$2,398,267	20%
Indirect AI/AN	\$65,688,647	\$123,931,513	89%	\$1,424,746	\$1,665,361	17%
<b>CDC Grand Total</b>	<b>\$108,079,306</b>	<b>\$167,637,959</b>	<b>55%</b>	<b>\$43,815,405</b>	<b>\$45,371,807</b>	<b>4%</b>

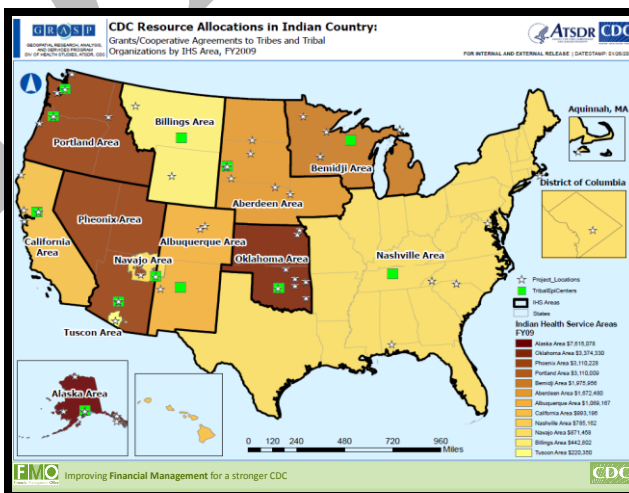
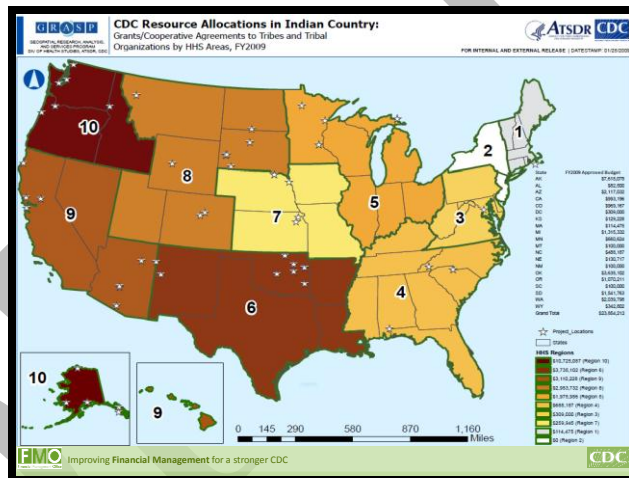
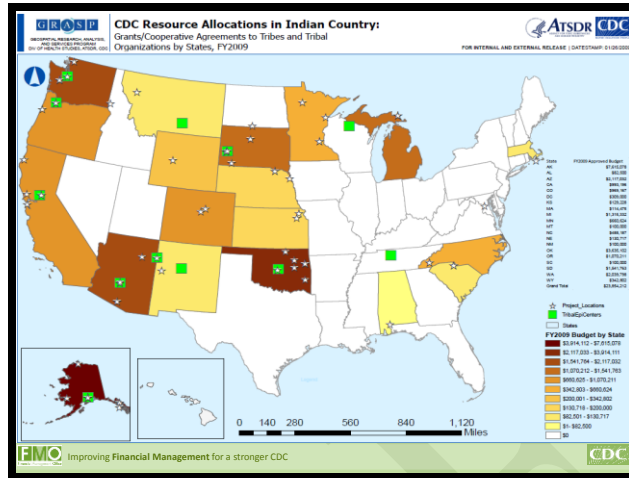
The following pie charts reflect the AI/AN 2009 funding allocation categories with the VFC and without the VFC:



AI/AN Fiscal Year 2009 funding (with VFC) in the amount of \$168 million represents 2% of the total CDC / ATSDR budget, while the \$45 million in AI/AN funding represents 1% of the total CDC / ATSDR budget.



Grants to tribes broken down by state, by HHS area, and by IHS area are reflected in the following three maps respectively:





In the above maps, green boxes represent the Tribal Epidemiology Centers and the stars are the actual project locations of the awarded tribal programs. These maps depict only those funds that are directly awarded to tribal government, tribal organizations, Alaska Native health corporations, urban Indian organizations, and tribal colleges.

TCAC CDC / ATSDR strategic funding direction is to engage in sub-budget committee collaboration; expand division-based involvement for health impact across CDC / ATSDR; engage in program project initiatives with CDC / ATSDR Financial Strategies Committee; increase visibility in budget submission health initiatives; align with CDC / ATSDR health goals and objectives for performance- and results-based management; and collaborate further with HHS and operating division (OPDIV) shared resource initiatives.

While unable to gain any information on the American Recovery and Reinvestment Act (ARRA) funding before this session, Mr. Curlee said he would hopefully be able to provide further information on this later. Though Mr. Curlee said he was also not certain what would be taking place regarding 2010, Dr. Frieden has alluded to a separate track regarding tribal activities, and that further information would be provided regarding that issue once some firm decisions were made regarding awards. Funding has been worked out the HHS on some of the ARRA funding activities that NCCDPHP will be managing.

Based on the comments throughout the day, it was clear that consideration must be given to how to make awareness of the tribal health activities funded by CDC more recognized. As evident in the funding provided previously, there is a cross-cutting network of activities with the CDC centers. While NCCDPHP is certainly a major contributor in that process, other centers are also engaged and involved. Early planning is very important.

Mr. Curlee noted that in a few days, the Fiscal Year 2011 budget would be rolled out by President Obama, which would include the HHS and CDC budgets in the huge package that would be provided for the public to see. Unfortunately, they were past the point for adding anything to the 2011 budget. However, FMO will soon be working on the 2012 budget initiatives, and CDC's 2012 budget will be provided to HHS by the end of May 2010. FMO will soon begin to work with CDC's program offices and centers to develop strategies. This represents another opportunity to approach health awareness for tribal nations and try to provide AI/AN activities in the process. The challenge is trying to put that together into a template and narrative that can be understood and can make a difference in health activities, so that CDC can review and consider that as they move forward in the budget process. This will begin with HHS initiatives that will be provided in the early submission. Hearings will also take place. During the summer, the Secretary's Budget Council will take place, which Dr. Frieden will be a part of. Later in September, CDC's submission request will be provided to the Office of Management and Budget (OMB). OMB will respond to CDC after working with HHS. About this time next year, the 2012 budget will be submitted for rollout as well. The budget cycle is a major process with a number of timing aspects. Mr. Curlee emphasized that tribal leaders give thought to potential initiative project-type areas that CDC could work with and work with tribes in considering moving forward.





## **Discussion Points**

- CAPT Snesrud pointed out that this year there are 78 cooperative agreements, while last year there were 76. At a time when dollars available have decreased, Tribes have increased awards received. There were two additional Tribal grantees and \$1 million increase over FY 2008. That said, there is also great diversity in the type of awards made to Tribes and Tribal organizations. Several of the major program categories ended and new ones developed as heard from NCCDPHP, so the players have changed. But in a time of having to do more with less, Tribes grantees have been able to increase both in the number of awards and in the total amount of resources.
- Ms. Hughes thought it was good to have the opportunity to consider submission of a project for 2012. The HHS consultation will be in March in Washington, DC but it is too late to have any serious impact there. However, they hope to be on the front in for the 2012 budget and to have some real-time input into the budget planning process. If they could think of some type of project initiative for consideration, that would be really great.
- CAPT Snesrud added that CDC and TCAC have been having this discussion about the budget for some time. The relationship between CDC and TCAC has been evolving both in understanding each other better and in building trust to enable us to work together more. We have now reached a juncture at which Tribes need to process and determine how to utilize the tools FMO spoke of to influence CDC's budget planning. A few TCAC members previously tried to establish a TCAC Budget Subcommittee but it seemed that Tribes knowledge of how to they could influence CDC's budget was yet not fully understood. Although it is true that all federal agencies have the same federal budget timeline, CDC is unique in that we address the public health needs of the whole nation, including AI/AN Tribes and people. What she heard Mr. Curlee and Mr. Franklin saying was that they are available as resources to answer questions, work with TCAC, and provide examples of projects that CDC has supported in the past. She encouraged TCAC to consider the re-establishment of that budget subcommittee.
- Ms. Hughes expressed her appreciation of the presentations they had heard, because there are many programs within CDC that tribes are not aware of on a routine basis. Even when they do receive funding, they still fall within that one focused category for five years and do not necessarily know about all of the other resources that are available. Gaining a grassroots understanding of what CDC has to offer is very important for TCAC.
- Ruth Ojanen indicated that Norton Sound Health Corporation, where she is a board member, is in Northwestern Alaska. She stressed that during the last TCAC meeting, while the site visit to Anchorage to the beautiful medical center may have given some the impression that tribes have it really good there, the only travel into her area of Little Diomedes is by airplane. Their roads are more like trails than roads, and they are closed in the summer. They were without passenger service for four months in the Bering Strait. While they had some helicopter services, there are regulations. The only way they could get off of the island was in a medical emergency, and the National Guard had to come. They had an outbreak of H1N1, so a team of doctors and other professionals did travel there by helicopter and worked around the clock for two days to treat those patients and immunize others. They took four patients back with them, but then at some point the patients needed to get back to Little Diomedes. That is, Alaska is not Anchorage. There are high rates of



suicide in certain areas, but based on the resources on the map, it is all centered in Anchorage. While they appreciate Anchorage and the medical center, access is not easy for many rural residents. She stressed that she meant no disrespect to the Anchorage facility because she herself would go there, but she wanted to drive home the point that many people are remote and have few if any services.

- Ms. Hughes said that brought to mind what the Aberdeen Area was experiencing with the snow storms.
- Dr. Bryan pointed out that on the map shown by Mr. Curlee that made it appear that resources were all centered in Anchorage, the green box was simply the Tribal Epidemiology Center because they wanted to point out where that was located. The stars represent several places outside of Anchorage. From what he knows about the funding stream from CDC to Anchorage, virtually all of the resources go to fund activities outside of Anchorage. He suggested that perhaps they could develop a different map to better illustrate where the resources are, and stressed that they realize that Anchorage is not all of Alaska.
- Regardless of the programs through which funds are allocated to tribes, Mr. Finkbonner pointed out that in the State of the Union Address, the President would announce that he plans to fix the FY 2010 budget for the next 10 years. He wondered what impact that would have on resources for the tribal programs. Shifting allocations could pose a greater concern for tribes. It is important to be mindful of the AI/AN health disparities, and if they really want to make a difference in the overall US health disparities, it is important to focus on the populations that have the greatest disparities.
- Mr. Valdo said that while it was great to see the \$1 million increase, it was not enough. He always becomes depressed during these meetings when he sees American Indians at the top in the categories even though they have the least numbers in terms of population. He took one of Mr. Curlee's statements as an open invitation to offer an idea for a study that perhaps could be incorporated into the budget. He would like to see that the overall budget allocated to tribes doubled. Their number one wish is to have their own Tribal Block Grant so that they are not fighting with the states anymore. This is currently a major hurdle. It was very good to hear the support from each of the groups which spoke regarding getting more support to the tribes. That is a major shift. To hear FMO say that as well was very enlightening. However, while it is nice to be screened, what then? What good is a test result when there is no one to take care of the results? Consideration must be given to ways to develop sustainable long-term programs within tribal communities. He requested further input from FMO about what might be a good initiative to put forth for the next budget cycle.
- Mr. Franklin agreed that it would be beneficial to have further input from FMO to offer some details about what a suggestion might look like. Should it be a wish list or something that has been implemented in a previous funding cycle that should have a tribal add-on?
- Mr. Curlee responded that they would provide, through CAPT Snesrud and Dr. Bryan, some type of template and some ideas to use as a framework. They can also provide good data. CDC's major mission is about prevention. He challenged TCAC to step up in order to take advantage of the opportunity to be considered in the budget cycle above where they have



been to date. A lot has to do with how ideas are presented and what catches the eyes and ears of Congress.

- Regarding current fiscal funding, Ms. Hughes inquired as to what CDC does with unspent dollars and whether there was a way that tribes could be considered for access to the unspent dollars.
- Mr. Curlee replied that at times, some programs do not spend all of their funds. The challenge for year-end spending is that proposed activities must be able to be processed through the Procurement and Grants Office (PGO) rapidly. A new grant will not get through this process. A supplemental is a possibility, as is a contract option that could be modified quickly that does not require a competition period. The agency sets priorities for any possible funding that might be available, how it can be utilized, and the conditions it can be met on. Sometimes this is related more to infrastructure activities at CDC because they are easier to process in a hurry. For example, information technology is very important at CDC, so they are sometimes able to make quick purchases for IT network equipment and such. They would probably also work through the national centers' program offices to consider priorities that they may have for any available funds that could take place in September as well. For example, working through NCCDPHP, perhaps something could be brought to light and if funding was made available and could be rapidly processed, it would be considered.
- Dr. Bryan pointed out that year-end funds are typically problematic. They always think that there is a windfall, and it is great, and they should jump on them. However, there are the practical issues of moving them out the door—spending them. Consideration must be given to how CDC spends the funds as an agency, who they should send them to, who can receive them efficiently, whether they are restricted from appending these funds to an existing cooperative agreement, et cetera. Then there is the issue that these are one-time funds, so it is difficult to build programs and hire staff based on those funds. While it is not a bad idea and such requests are always considered, there are realities. For \$10,000 to \$20,000 it is not worth the effort unless there is a very easy niche for those dollars. This is becoming increasingly more difficult to do. While he understands how wasteful it is if they cannot spend year-end funds, he has a dismal opinion of these funds just because of the practicalities. They must think creatively together about the realities of using those funds and getting them out the door.
- A CDC representative suggested that to alleviate some of the rush, they have a couple of one-page ideas already prepared. Her program funded a great project in Alaska with year-end funding of \$150,000 to conduct a self-collected screening project. It is one-time, but it is still a good thing to do on a proactive basis.
- Mr. Trudell pointed out that there are a number of studies, best practices, et cetera. They must think about how to tie all of those together and assess them and assess communities so that these can be implemented to other communities. Each community is different. Perhaps they could develop a plan to put together a team of health educators who would visit the communities to help them conduct an assessment to implement these things. If the communities do not know how to implement programs and do not have the funds to do it themselves, why not use some of the year-end funds to have teams work on this.



- Dr. Bryan noted that if they had some boilerplate, ready-made plans, perhaps they could include some language in new FOAs being published that would offer some flexibility for moving money out if it became available. They would have to clear this with PGO. There are a couple of FOAs in the works that will target Indian Country. It will require being ready to receive. If they have cooperative agreements with national organizations, coalitions, or groups of tribal organizations of some sort with a pretty broad initiative, this could be a place for a legitimate tag on should funds become available.
- Mr. Curley indicated that the Indian Health Board receives PHEP funds through the State of Nevada, and has a great relationship with them. One problem they have experienced in Nevada with the carry forward funds at the end of the year is that the program year begins in August of each year. They begin developing their applications in January, submit them on time, but do not receive the notice of award until December or January of the following year. This gives them only about four months within which to spend a tremendous amount of funds, and then they are told they can only carry a certain amount over, or that they are one time funds that cannot be carried over. They have to spend the previous year's carry over first. That puts programs back. Things that should have occurred in the beginning are having to be carried forward. Funds become mixed and it is then unclear how to carry these forward. The timing of when funds are dispersed creates these types of issues, at least in Nevada. Recently funds came out and the IHS was requested by the state to match these funds with tribal funds. They submitted a plan that said they would use 638 funds to match those funds. It took three months to correct the misperception that those were federal dollars and federal dollars cannot be matched with federal dollars. Somewhere within CDC, there are people who need to understand that 638 funds can be matched with CDC dollars. He wished they could find a way to streamline the financial award system so that they do not have to constantly make carry forward requests.
- Mr. Curlee responded that they have been reviewing this for some time, particularly with respect to the preparedness grant that goes out late in the year. There is an initiative underway within CDC currently. One of the objectives is to try to move many of the fourth quarter activities at least into the third quarter, and sooner if possible. This has been raised before the Management Council. This will take a significant amount of work in terms of making changes in performance periods, grant periods, and going through recycle areas. As they engage in this process, they will work on communications with partners as well. It takes time, but if done correctly, award and funding announcements can come out earlier in the process. This is a major goal at CDC. While he could not say that it would be accomplished within this year, the goal is to make major steps this year. He indicated that he would take these comments back to the committee.
- Ms. Begay expressed the same concerns stated by Mr. Curley. Navajo Nation receives funding through two states, New Mexico and Arizona. Those two states have their own complex financial systems. When the funds finally get to the Navaho Nation, the Navaho nation as a tribal government has its own complex financial system. The timeline gets even longer due to this. Their bioterrorism preparedness program has had to deal with those situations. The Navaho Nation has developed recommendations and expressed concerns about this situation; therefore, the Navajo Nation has submitted numerous concerns and position statements to CDC through various forums requesting consideration for direct funding to the tribes rather than through the states. This is a great concern and the Navajo Nation intended to express this during the consultation with Dr. Frieden on January 28, 2010.



### Open Discussion / Recess

During this session, the group attempted to set a time for the next TCAC teleconference and a location / host for the next face-to-face meeting. CAPT Snesrud suggested institutionalizing regular times of the year for face-to-face, as well as a standard timeframe for teleconferences. It was agreed that Fridays during the 1:00 PM EST timeframe seemed to work best for the teleconferences as a rule, while the end of January to the end of February and August worked best for the two face-to-face meetings. Given the number of other meetings already scheduled and a variety of conflicts, it was agreed that everyone would return home, review their schedules, and email CAPT Snesrud with their availability for the next teleconference. A suggested date of the second week of February was made for the next teleconference. CAPT Snesrud stressed the importance of scheduling a teleconference as soon as possible to address the issue raised by Mr. Curlee regarding the possibility of submitting a special project for funding. Ms. Sebattus offered to check whether Niagara could host the next face-to-face meeting.

*With no further comments, questions, or business posed, the meeting was officially recessed until 8:00 AM EST the next day.*

### Wednesday, January 27, 2010

### Call to Order and Opening Prayer

CAPT Snesrud called the meeting to order, followed by which Mr. Secataro offered the morning prayer. Ms. Hughes requested that everyone sign the Talent / Consent Waiver to be submitted to Natalie Greene from MTC, given that photographs would be taken during the consultation on January 28, 2010.

### NCEH / ATSDR

**Annabelle Allison, PhD**  
**Tribal Liaison / Lead Public Health Scientist**  
**Office of Tribal Affairs (OTA)**  
**National Center for Environmental Health (NCEH)**  
**Agency for Toxic Substances and Disease Registry (ATSDR)**  
**Centers for Disease Control and Prevention (CDC)**

Dr. Allison indicated that the Agency for Toxic Substances and Disease Registry (ATSDR) was created by Superfund Law in the 1980s to protect health and environment from hazardous substances. ATSDR is really known and recognized for conducting various types of public health assessment of waste sites, health consultations, health surveillance, registries, and



training / outreach. The National Center for Environmental Health (NCEH) is part of CDC. About four years ago, NCEH and ATSDR merged to some extent because they both address environmental health topics. NCEH is the lesser known of the two entities, and is really known for its research to investigate effects of environment on health in the laboratory and the field. They also conduct some surveillance and engage in environmental emergency response and education and training.

The past year has been very busy. Dr. Allison has been in the Office of Tribal Affairs (OTA) just under two years. Much of what she has been doing has pertained to gaining visibility and conducting outreach on behalf of her program and NCEH / ATSDR. She has attended several conferences, meetings, and forums to advocate for a tribal voice and input into the NCEH / ATSDR national conversation and has very active in coordinating efforts with the Navajo Nation and others regarding uranium assessment and remediation. This year was the last year of a five-year cooperative agreement with two Tribal Colleges and Universities: Turtle Mountain Community College in North Dakota and Dine College in New Mexico. One of her efforts during 2010 will be to find additional funding to continue OTA's efforts with Tribal Colleges and Universities. She hopes to increase the number of AI/AN in public health and environmental health careers, and to work with Tribal Colleges and Universities to further their accreditation programs. Related to visibility will be collaborating internally and getting herself known to the various divisions within NCEH and ATSDR and working with them on various projects.

The most recent announcement is that effective January 15, 2010, Dr. Howard Frumkin, who was the Director for NCEH / ATSDR, accepted a new role as Special Assistant to the Director for Climate Change and Health. Temporarily in his place is Dr. Henry Falk, who is serving as the new Acting Director for NCEH / ATSDR. A search for a permanent replacement is underway.

For 2010, Dr. Allison has activities planned regarding the NCEH / ATSDR National Conversation, the goal of which is "To create an action agenda for strengthening our nation's approach to protecting the public from harmful chemicals." This will be 18 months in length and includes a myriad of partners and the public. In mid 2009, Dr. Frumkin and others created this National Conversation to go across the country to determine how they could improve the services that NCEH / ATSDR offer. Dr. Allison has strongly advocated for tribal representation. She met with national tribal organizations on 9/11/09 in DC to share information about the intent of NCEH / ATSDR and to hear about ways they could get the word out to Indian Country about the National Conversation. The National Conversation has six workgroups and tribal representatives, which are as follows:

- Scientific Understanding: Susan Hanson, Shoshone Bannock Tribe
- Policies & Practices: Kristin Hill, Great Lakes Inter-Tribal Epi Center
- Chemical Emergencies: Syndi Smallwood, Pechanga Band of Luiseno Indians
- Serving Communities: Steve Crawford, Passamaquaddy-Pleasant Point Tribe
- Education & Communication - Rosemary Ahtuanguaruak, Inupiat Community of the Arctic Slope
- Monitoring: Nancy John, Cherokee Nation

OTA's goals and strategies or the National Conversation is to develop a national tribal environmental health group to be composed of the six workgroup representatives, tribal professionals, national tribal organizations, and federal agencies. The purpose of this group will



be to provide support to the six workgroup representatives and assist OTA with identifying priorities of tribes and develop a strategic plan.

Regarding the health and environmental impacts of uranium on the Navajo Nation, in which Dr. Allison has been heavily involved, mining was done on the Navajo Nation from 1944 to 1986. Approximately 4 million tons of uranium ore were mined and milled. There are 500+ abandoned uranium mines, 4 inactive milling sites, former dump site, contaminated groundwater, and structures built with contaminated materials. There have been Congressional hearings since the 1990s. In October 2007, testimony was offered before the House Oversight & Reform Committee. Representative Henry Waxman (CA) and select committee members requested five federal agencies (e.g., EPA, IHS, BIA, DOE, NRC) to develop a five-year plan to assess and remediate. They meet every six months to provide updates on their progress. In 2008, CDC / NCEH Health Studies Branch provided technical support to the EPA and IHS on a water and urine sample study at certain households. In September 2008, Representative Waxman requested NCEH / ATSDR to participate in the progress report meetings.

In December 2008, as part of the NECH / ATSDR efforts to assist the IHS, they conducted Grand Rounds Training at five IHS clinics to inform physicians about the impacts of uranium on the Navajo people and to give them some guidance on how to diagnose and screen for patients who suspect that they have been exposed to uranium. In July 2009, shortly after a couple of water studies were conducted and sample analyses were finalized, NCEH / ATSDR provided training to CHRs who have been crucial in helping to get the word out about the on-going studies and informing the various communities about the impacts of uranium and what it means for them, and recruiting them to participate in the water sampling and urine sample collection. The training focused on how to disseminate sample results back to the community members. In preparation for this training, NCEH / ATSDR developed a booklet that the CHRs take to households as they talk about uranium. The book includes CHR talking points and information that the household members will see. This is a very effective tool, and the concept was to give the CHRs information that they could feel comfortable about discussing. Much of the information was translated into the Navajo language.

In FY 2010, there is potential funding coming down the pike for ATSDR to conduct an epidemiological study of non-occupational health impacts from past mining and milling operations. They are waiting now for confirmation. Once that occurs, they will release an FOA. The majority of the funds will be allocated externally for an entity to conduct the epidemiological study. While ATSDR will not conduct the study, they will offer guidance and oversight regarding the design and implementation. Because this is an epidemiological study, they are hoping to have continued funding for at least three years. However, this will depend on the amount of the funding allocation.

In closing, Annabelle Allison said she hoped to get out to Indian Country more during 2010 to visit with tribal communities. She also shared her personal contact information: 770-488-3991; [AAllison@cdc.gov](mailto:AAllison@cdc.gov).

### **Discussion Points**

- Mr. Secatero indicated that in the village next to where he lives called, trains were being filled up and moved out without covers, so the wind blew dust on the grass. The animals were exposed to it. Years later, many people complained about stomach pains and there



are many stomach cancers due to this mining. He wondered whether Dr. Allison had heard anything about reopening some of the mines.

- Dr. Allison responded that a couple of exploration companies have gone back to New Mexico to see if they can find uranium to mine. There is political controversy because they are thinking of exploring or have explored areas near the Grand Canyon, which is adjacent to the Navaho Nation. The New Mexico Legislature has had meetings about this beginning in the Fall of 2009. They are thinking about trying to do something similar to what the Navajo Nation is doing in terms of assessing the impacts of mining. There are numerous issues the pueblos are dealing with, and she expressed her hope that they would be able to find the funding to conduct further assessments. As far as exploration goes, it is back and forth in terms of support. For economic reasons, people in the area need jobs and they have to balance that with some of the environmental concerns that surface as a result of that. It is up in air in terms of whether mining will move forward.
- Ms. Begay indicated that this was the first time she had met Dr. Allison, although she had been to the Navaho Nation numerous times. Navaho people call the uranium “yellow cake.” There are numerous horrific stories about the tragedy and death this yellow cake has brought upon the Navaho people and the Navajo Nation. They have heard stories about children who have played in contaminated water, and spouses whose husband worked in the mine and came home and shook off their clothing, the dust from which their families inhaled, causing pain and suffering. They have also heard of children playing the mines that were left open when companies moved away. Overall, the Navaho Nation has staunchly opposed anymore uranium mining on the Navajo National. The Navaho Nation President, Joe Shirley, has offered a great deal of testimony. The Navajo Nation Division of Health Director has submitted numerous written testimonies and offered oral testimony. It took a combination of efforts on the Navajo Nation by numerous bodies of Navaho groups, and people adversely affected by uranium. Dr. Klaus has offered endless technical and professional expertise. Their attorneys have collectively worked together to cease any further discussion about uranium mining on the Navajo Nation and to request a long-term study assessment on the adverse effects of uranium on the environment and on human health. Therefore, she was very encouraged to hear about this potential funding to conduct assessments. They have requested that CDC and ATSDR engage and be part of the five federal agencies to play in a central role in conducting research and assessments. The Navajo Nation has requested that these two agencies also prepare a five-year coordinated plan and budget development to support the five-year Waxman plan. She said she was encouraged to hear this report and indicated that she would take the information back to the Navajo Nation.
- Dr. Klaus added that the Navajo Nation CHRs did a fantastic job. They conducted every single interview in a very short time. She did not know any other group of people in world who were called on regularly to put aside their own work to do all of these extra things.
- Mr. Valdo expressed his hope that the study would include the neighboring communities, because not only Navajos, but also others worked in the mines. There have been over 200 applications by mining companies for pilot programs to locate the best quarries. He did not think these companies would spend money for 200 pilot wells for nothing. Uranium ore used to be over \$1,000 per pound, so it is very lucrative. Ultimately, they would like to be able use the results of the study to fight the mines. It has been an ugly battle and racial tensions have escalated.





- Mr. Antone inquired as to what CDC had done following their commitment to Alaska to help the Navaho Nation.
- Dr. Allison responded that in August 2009 during the last TCAC meeting, there were representatives from the NCEH Health Studies Branch who have conducted the most comprehensive studies on ATSDR's behalf. They continue to be committed to work with the EPA on additional water sampling at unregulated wells that have been identified. There are several on the reservation, and as they talk to families are finding out about ones they missed in the first round of sample collection. They have visited those additional wells and have offered to collect additional urine samples from individuals who are interested in learning whether they have been exposed. She indicated in the CDC Recommendations and Responses, #24 speaks specifically to the Navajo Nation, and that in their briefing books there was a longer summary of two studies conducted thus far. They have not been able to make a connection between what is in water and human health exposures to uranium, so there are other things causing exposure. There are many pathways that are not necessarily thought of that are out of the box, like workers bringing the dust home on the clothes they wear, the family members who washed those clothes, children playing on the floor where a person walked and dropped materials, children playing on tailing piles, et cetera. Different about ATSDR's study is that they are focusing on non-occupational exposures. They also anticipated additional work with EPA and IHS related to uranium. In terms of Alaska, the Health Studies Branch also presented on some of the work they would like to do in that area, and that is moving forward as well.
- Kristin Hill, the Policies and Practices Work Group representative of the National Conversation work groups, said she was pleased to have the support of Kathy Hughes, who advanced her name forward to apply for this role. She was honored and pleased to be selected for the role. The Policies and Practices Work Group has had several phone conversations, and their first in-person meeting convened in November in Washington, DC. They have developed the charge, which she believes almost has the support of the full group. This has been a challenge to listen to the multiple perspectives of all of the various agencies, advocacy groups, business interests, et cetera. These groups can be highly charged and there are a lot of smart, energetic people on all sides trying to hash out these issues. This group has sense that they will achieve some common ground. She has been thinking about how to talk to the TCAC more about policies and practices, and requested input regarding how she might connect with them in a two-way conversation.
- Dr. Allison said that the creation of the Environmental Health National Group she was hoping to establish would provide additional input and feedback on some of the views and perspectives. It really is meant to be a two-way support system.
- Mr. Antone said they are beginning to see mines coming back like the Rosemont Copper Mine and the possibility of exploration in the Grand Canyon, so there is a multitude of issues across Indian Country. This is a good time to bring that working group together.
- Steven Matles from the Indian Health Board of Nevada thanked Dr. Allison and said that she sold herself short. ATSDR helped them with a methamphetamine summit. One of the major takeaways from that summit for the folks from the tribal clinics and the CHRs pertained to the secondary effects of methamphetamine in children. It has helped a number of tribes in



his area with early detection so that appropriate interventions can be instituted fairly early, particularly in that population.

- Dr. Allison indicated that ATSDR has regional representatives who share space with different EPA regions. There are 10 regions and ATSDR has representatives in all of them. Libby Vianu is the Region 9 representative. She is very passionate about working with tribes in her area. Dr. Allison indicated that she would pass along Nevada's appreciation to her. She has kept Dr. Allison updated on the activities, and Dr. Allison was happy to hear that the experience was positive.
- Mr. Franklin said it was disturbing to hear 1950s Indian policies coming back into Indian Country. He encouraged tribes to help fight it on that front to help Dr. Allison, and that the NIHB would do what they could, as would California to contribute to the effort (e.g., resolution, et cetera) he encouraged ATSDR to reach out and let them know, especially NIHB. It is even scarier to hear that the issue is being pushed. The Supreme Court made their decision and they can contribute as much as they want now. All tribes must support each other.
- Ms. Hughes reminded them that the previous day, a reference was made as tribal status for treatment as a state under the EPA. That is also a very effective tool. A company wanted to open a mine in Upper Michigan. Through the formal process with EPA and the status of treatment as a state, the tribe had their input and was able to prevent it. More tribes need to take advantage of that policy and practice.
- Mr. Trudell reminded everyone that there are also uranium and mining problems in Western South Dakota stemming from mining in the Black Hills. He requested that ATSDR keep this in mind as they conduct their studies.
- In response to Mr. Franklin's comments, Dr. Hill said that the tone and nature of the work group participants is going to be proactive, with policies to examine potential impacts before they occur. That is, they want issues addressed in the form of health impact studies *before* mining or any other environmental issue takes place, rather than spending money to assess something *after* it has already occurred.
- Ms. Hughes inquired as to how CDC / NCEH / ATSDR could be a formal participant on the Waxman group.
- Dr. Allison responded that a request would have to go to Representative Waxman and the committee. Despite their informality, they are participating actively. Regarding some of NCEH / ATSDR activities, she has 16 pages of various activities, but she wanted to keep her presentation short. However, she did not want to sell short the fact that NCEH and ATSDR representatives are working diligently on various tribal projects. She said she was very happy to report that in 2010, all of the divisions within NCEH and ATSDR have some tribal projects, which she thought was great. In response to Dr. Hill's comment about examining issues before they occur, Health Impact Assessments (HIAs) are becoming very popular. These assess the impacts of public health prior to the development of a facility, plant, et cetera. These are often being conducted in conjunction with National Environmental Policy Act (NEPA) studies. Europe has used HIAs pretty effectively over the past few years. This practice is beginning to be adopted in the US more. Alaska has used the HIA process to assess potential mining sites. It is information currently in that there is no



rule or regulation that mandates this, but there can be a push to look at public health impact proactively.

DRAFT

**CDC in Response to TCAC Recommendations / Organizational Improvements**

**Dr. Ralph Bryan, Senior Tribal Liaison for Science and Public Health  
Centers for Disease Control and Prevention (CDC) /  
Agency for Toxic Substances and Disease Registry (ATSDR)**

**CAPT Mike Snesrud, Senior Tribal Liaison for Policy Evaluation  
Centers for Disease Control and Prevention (CDC) /  
Agency for Toxic Substances and Disease Registry (ATSDR)**

Dr. Bryan explained that the document provided to TCAC members titled “A Summary Report for the 4<sup>th</sup> Annual CDC Consultation January 28, 2009: Resource Allocations, Strategic Partnerships, and Capacity-Building” is basically the CDC component of the HHS annual report just packaged separately for TCAC’s use. This is a comprehensive highlight similar to the presentations delivered the previous day of all of the activities across the agency that deal with Indian Country. The first page of this document is a synopsis of what was presented the previous day by Mr. Curlee of FMO about CDC’s resource allocation. This is a nice overview of CDC’s general responsiveness to TCAC and the Tribal Consultation Sessions convened over the years. Not everything is listed, but it is fairly comprehensive. The document provided to TCAC members titled “CDC Tribal Consultation Advisory Committee (TCAC) Update on Recommendations / Response January 2010” lists 24 of the cumulative formal recommendations since the inception of TCAC in 2006. The recommendations are listed more or less chronologically. He and CAPT Snesrud will continue to add to this list as formal recommendations are delineated during TCAC meetings and Tribal Consultation Sessions. No recommendations have been removed from the list to date as completed and done, because many of the activities, once implemented, are on-going. Some of the activities are partially implemented, in progress, or in transition. Of the 24 formal recommendations, a number have been implemented and are on-going. During this session, he and CAPT Snesrud wanted to give TCAC members an opportunity to respond to this document, offering feedback with regard to whether this format is the most useful versus more succinct, tabular type matrixes presented in the past, which are shorter but contain less detailed information about what CDC has been doing in response to the recommendations.

CAPT Snesrud added that what they mean by “CDC having an open door policy” is that although they do convene two specific bi-annual Tribal Consultation Sessions during which testimony can be provided by any and all tribal leaders, Tribal leaders still have the option to provide testimony and/or consult with CDC at any of the HHS regional and national sessions, and any individual Tribe can choose to request a program specific or broader consultation to address their questions and concerns. As in the past, Tribes can always submit inquiries, testimony, or recommendations if unable to attend the in-person TCAC meetings or Tribal Consultation Sessions. Regarding the previous day’s discussions about where the proponent for Tribal Affairs will be within CDC and the proposed new OSLS, she referenced participants to the bottom of page 3 of the “CDC Tribal Consultation Advisory Committee (TCAC) Update on Recommendations / Response January 2010.” She also drew their attention to pages 8 and 9 of this document regarding specific resources that are building on an orientation to tribal leaders to understand more about CDC.



## **Discussion Points**

- Responding to an inquiry from Mr. Franklin, CAPT Snesrud indicated that since April 2008, the Office of Minority Health and Health Disparities was in the Office of the Chief of Public Health Practices of which Dr. Bailey was the Chief. She noted that they would hear more later in the day during the overview about the CDC reorganization and proposed new organization of the agency.
- Mr. Trudell expressed concern that typically when there is reorganization, the entire education process must start over in terms of the tribes' positions, feelings, what they are trying to attain, et cetera and tribes must relearn everything about the new organization. It seems as though every time tribes begin to make headway, the "rug is jerked out from under them."
- CAPT Snesrud replied that Tribes "hit the ground running," and were picking up momentum in the journey of assisting CDC and the Tribes to work and partner together. In particular, the TCAC has greatly lead this effort. CDC is gaining a much greater knowledge and understanding of the sovereignty of tribes and the government-to-government relationship and has come a long way to increasing Tribal access to is resources.
- To allay Mr. Trudell's concern, Dr. Bryan added that the agency was undergoing what was termed an "Organizational Improvement Process," so it is not a reorganization per se. It is just an enhancement of the existing organization. That is a nuance, not a dodge. In terms of the OSLS, TCAC's recommendation early on to consider a Tribal Office has been taken very seriously in this process. He said he thought they would be pleased with the results when they heard more about what was in the works in terms of more formally establishing a Tribal Office, unit, entity, and organizational structure within the OD family of offices at CDC that includes a commitment from the agency to provide additional staff and adequately resource that office so that they can do a better job of serving tribes. He assured them that much of what was occurring was because of TCAC's input to date. Dr. Bryan and CAPT Snesrud are fairly optimistic and pleased with the way things are currently headed.
- CAPT Snesrud stressed how vital TCAC members are in this process, now and throughout the journey. She acknowledged that collectively much progress has been achieved since 2001 when CDC first began hosting Tribal meetings to get guidance and assistance at CDC in terms of how CDC works with Tribes. Nevertheless, she said she understood their distrust of CDC as another federal agency that tribes were continuously having to educate and hold accountable.
- Mr. Finkbonner said he liked the "CDC Tribal Consultation Advisory Committee (TCAC) Update on Recommendations / Response January 2010" document as it helped to put into context some of the efforts they were trying to address around the table. It will also help him when he returns to his delegates to seek a primary delegate to serve on TCAC rather than him as the alternate delegate because it gives them something to work with. To reframe the concept, it is not so much distrust as it is that CDC and public health both tend to be abstract thoughts with tribal leadership. They do not quite understand what it is, so this document will help to put TCAC / CDC efforts into context. He thought the document was moving very much toward a strategic plan, which he completely supported. Sometimes the process of developing a strategic plan is more valuable than the document itself. What is also great about strategic plans is that when there is a change in leadership, such as with



new political appointees, the strategic plan stays in place and gives them the institutional history that went into building up those efforts.

- Dr. Bryan replied that the previous Monday afternoon, he and CAPT Snesrud met with OSLs Deputy Director Karen White. They spoke with Dr. White and Kristen Brusuelas about the need for rapid action in terms of strategic planning on this front.
- Mr. Antone noted that he had been one to hound CAPT Snesrud and Dr. Bryan because sooner or later the tribes are going to ask them what they are doing. He thought the document was something they could move on, and which could help them gauge what was being done and what was not. At this point, they must identify who will be the recipients of the report. While some tribes have direct funding, there are 564 tribes, so TCAC / CDC have barely scratched the surface. Most of the tribes that have received grants from CDC have some capacity, but there are many that do not. This document should be submitted to Dr. Frieden, and he should be educated about tribes.
- CAPT Snesrud acknowledged Dr. Bryan for pushing through, partly as a result of the H1N1 crisis, the formation of the AI/AN Population Team within CDC's Director's Emergency Operation Center (DEOC). Drs. Bryan and Tom Hennesey are the team leads, and CAPT Craig Wilkins and Myra Tucker are the critical players who have operationalized that team. While this has been specific and germane to the H1N1 initiative, it truly has gotten tribes "on the map" in a very prominent way that will be utilized in many other efforts. Referring to page 15 of the recommendations document, and incredibly exciting, CAPT Snesrud noted that "Knowledge to Action Science Clips" had been developed as well in response to the best practices recommendation.
- Ms. Hughes said she thought the recommendation document would help to keep them on task. She expressed her hope that if this led to the development of a strategic plan, to her that would be a more formal document. She hoped that this was the plan.

### Updates from OS / Intergovernmental Affairs

#### **Stacey Ecoffey, Principal Advisory for Tribal Affairs Intergovernmental Affairs Department of Health and Human Services (HHS)**

Ms. Ecoffey reported that generally, many changes are underway at HHS department-wide. She did not think the changes were to be feared. More so, the changes are positive for Indian Country and should elevate tribal issues the HHS agencies. There are many new political leadership members who have been around Indian Country for a long time. This has made their interaction in the Office of the Secretary much easier. They have a lot more access, movement on issues, et cetera. They played a lot of defense in the last administration; whereas, this time there is more positive action. The Secretary plans a lot of interactions with Indian Country. Ms. Ecoffey hopes to have a lot more staff in her office, which should enable them to spend much more time with the tribal consultation groups in various agencies. She said she thought they had some good career staff at CDC.



With respect to the Budget Consultation, she encouraged tribal leaders to join the calls to help plan the agenda. Some of the issues HHS would like to discuss include the consultation process, and how HHS does things with consultation as an overall department. President Obama sent out a memo about Executive Order 13175: Consultation and Coordination With Indian Tribal Governments. HHS has always taken very seriously and complied with this order. There are areas for improvement, and they evaluate the process every few years. It is time to evaluate this now. HHS's memo back to OMB and the White House is in the clearance process. The White House has not decided whether they want to share all of the plans from the agencies or how that will work, but HHS is very open to sharing what their plan is and the comments that they received from Indian Country on HHS's policy.

Though somewhat different for the tribes this year, HHS is setting the dates for the consultations and is focusing primarily on the consultation policy process, the agency policies, and open tribal leader comments on consultations in general. HHS will convene one-day sessions throughout the country in each region, with the exception of Regions 9 and 10 which will have two sessions given the large number of tribes in those two regions. She hoped the Secretary would have a letter soon and that she would be able to share the dates by the next week. These meetings will be convened from the end of March through the beginning of May 2010. They also plan to visit Indian Country during that time frame as well. The plan is to look at a few tribes in each region, and then to build up to some larger HHS trips throughout the year. They plan to form a Federal Tribal Work Group that will meet over the summer. They will ask for nominations from the tribes for that work group in May or June, and will convene the first meeting of that group in July to review all of the comments heard internally and externally because this is a partnership and develop a better plan and determine which agencies need to be targeted to develop consultation policies. CMS's plan is moving forward, and there are some really good people in the Administration for Children and Families (ACF), so some good things should come out of that office for Indian Country. They also plan to target NIH and AOA soon to develop consultation policies, and will probably wait to target FDA so that it is not overwhelming to HHS and the tribes.

In early summer, HHS hopes to convene a meeting with the Chairs and the Co-Chairs of the four Tribal Advisory Groups and the Secretary and Chief of Staff and Ms. Ecoffey's boss. This is now agreed upon, and they hope to plan this so that tribal leaders are not traveling to DC for anything extra. It will be important to prepare to discuss tribal priorities with the Secretary and Chief of Staff. They will most likely create a Secretary's Tribal Advisory Committee, but the charters must be in order with the groups. The attorneys are likely to scrutinize this closely, so they hope to have all of the charters and policies in place. Hopefully in the fall, they will be able to roll out and start this process. In the meantime, the charters and policies must be completed. HHS is excited because they will be the first federal agency to have a group such as this.

There will soon be a budget roll out, for which there should be a webcast. Ms. Ecoffey indicated that she would get the link for that to everyone so that they could see it. There will be documents on the budget that she will also share with TCAC members. She said that she was thoroughly enjoying the new leadership at HHS. It is a lot different to have a Chief of Staff who is very Indian-friendly. She stressed that when the tribal leaders were developing their testimonies for the budget consultation, they would not have to do a 101 this time. She suggested using concrete tribal-specific examples, such as "If the budget is not improved in this area, X will increase" so that HHS can see where they need to target specific items in the



budget for programs that will benefit Indian Country. While they could do somewhat of a 101, this time there would be some Indian-friendly faces who do not need this.

While she could not always guarantee the secretary, Ms. Ecoffey encouraged tribal leaders to visit HHS. Either HHS is doing their job really well or tribes just have not requested it, but not a lot of people have come in to meet with the new leadership. They really enjoy the tribal advisory committees and talk about them in staff meetings, with regional offices, et cetera. The regional offices are also going to be much more engaged with tribes. Some tribes have good relationships with the HHS regions, but they should see more. They have been encouraging the regions to meet with everyone in their areas and talk about things that they can do in their regions specifically with the states that they serve and the HHS programs that fall in those states, and how they can improve interactions between the tribes, the states, and HHS.

The consultation report should be published by the end of March. The HHS website is being improved. The agenda will include a lot of information about H1N1. There has been a lot of good movement and collaboration between the internal agencies to outreach to Indian Country, as well as with the Department of the Interior and Homeland Security. It has been nice reaching out to all of them, especially Homeland Security, because they really want to be a part of the process and be helpful to Indian Country. They just do not know quite how to do that, but the President's memo has made it a lot easier for the inner agencies to talk to each other about how to do consultation.

### **Discussion Points**

- Ms. Hughes found the possibility of a Federal Tribal Advisory Committee directly to the Secretary of HHS to be very exciting. Having a voice at that level is an issue of great importance to tribes. Although it is a challenge for the tribal leaders to participate in all of the consultations, expanding these relationships is very important for Indian Country. It is good to see progress with policy, funding, et cetera because of the voice at so many tables now.
- Mr. Secatario wondered how TCAC was doing, and what else they needed to do. There was a question about by-laws and designating committee members, and he wondered if that had been resolved.
- Ms. Ecoffey responded that it is a policy issue. Each of the advisory committees do things so different, one cannot be compared to another. All four of the committees do some amazing things. It just depends upon the issue. For the most part, all of the committees are on equal footing. Some of them have been established longer. Some work on more technical issues, some work on broader issues, some focus more on funding, and some focus more on programmatic issues. With respect to the question about the by-laws, it is very important to keep good records. Some of that does fall back on the HHS agencies. Some have not been keeping official records consistently. A major issue regarded how a representative at the table is designated. This has been ironed out. HHS does not care who sits at the table. They simply need the person to be designated by a tribal leader. That has not been done in some cases. Another issue is that HHS does not want to contract out their inherent government responsibility to a contractor. The agencies should have direct relationships with the tribes. In moving forward, the Directors of HHS's agencies should be sending letters directly to the tribal leaders. They should not have to go through the Indian Health Service and the Area Directors. Because they have advanced in their relationships





with tribes, HHS wants to improve that process and have that direct relationship. They have not had that in the past.

- Ms. Hughes indicated that every TCAC member had a letter from an elected official designating them to be on board. There is some paperwork that needs to be completed to solidify this.
- Mr. Trudell pointed out that sometimes they forget to commend their young people as they move up the ladder. He commended and congratulated Ms. Ecoffey for moving up the ladder, and told her to keep up the good work and keep opening the doors.
- Regarding agencies having to funnel letters or other communications through the IHS, Ms. Begay pointed out that each tribe is different and each tribal government is different. They operate their protocols differently. There has been some concern about how those letters are disseminated to the Navajo Nation. The Navajo Nation has a three-branch government. There has been some confusion and there was some concern with the recent IHS Director "Dear Tribal Leader" letter asking for designation to her advisory group. There was some conflicting designation from the Executive Branch and Legislative Branch of the Navajo Nation government. She wondered how this current worked from the HHS's standpoint in terms of how letters are sent. This can be a sensitive issue, and there can be competition.
- Ms. Ecoffey responded that currently the process for HHS is that from the Secretary, the letter goes to the Tribal Chairman of every tribe. For federal agencies such as HHS, it is not feasible to have 565 individual processes for every tribe in the US. They also utilize Regional Directors, her list, and national organizations to get these out. Consideration must be given to how to determine a mechanism that works for everybody. This will likely be negotiated out once they receive all of the comments over the summer.
- Mr. Valdo reminded everyone that under the Federal Advisory Committee Act (FACA), the designated representative is an elected official who can have alternates who are not elected. They also must remember that consultation is not staff to government, it is government to government. Some organizations have forgotten why these committees were created, which is to serve the Indian people.
- Unlike the Navajo Nation with 88 representatives, Ms. Hughes indicated that Oneida only has 9 and they still have challenges occasionally. Everything basically does come into the chair's office. Their internal process requires the chair's staff to distribute to the rest of the government. From a federal perspective, it is too challenging to know what all of the tribes are doing. She believes that part of the responsibility will rest with the TCAC. When there are vacant positions, each council member takes the responsibility of trying to fill those. Every advisory council must take this type of responsibility to ensure that areas are represented, even though HHS sends the letters. They all have a national presence because of their participation, and they have contact that they need to use because of that.
- Mr. Franklin said that he is a single issue elected councilman. His tribe elected him to represent them as their health delegate, so he wears a number of hats and is pulled in every direction. Even though he is elected just to represent health, he does not have time enough for that. He sees the wisdom and importance of having a letter from a tribal government for an elected tribal official that gives someone a seat at the table to speak on behalf of federally recognized tribes, but they need the leeway to appoint someone to attend on their



behalf should they have to prepare for other activities. The most important thing is to ensure that the area is represented in the way that the tribal leaders see fit. He commended Ms. Ecoffey on her efforts. California has many issues, and they took the liberty of visiting HHS, which has been very rewarding for them. In the previous administration, talking to the White House was a dead issue and everyone knew it. With this administration, that is no longer true. Tribes need to take advantage of this. He encouraged everyone to keep in mind that this could all change again, so if they do not place everything that has been built up for tribes on solid foundations, they could be knocked down again. FACA is the foundation.

- Ms. Ecoffey agreed, stressing that during this window of opportunity, they must attempt to put as many concrete, sustainable things in place as possible. Tribes benefit from being FACA-exempt committees. The tide could change if they do not follow some of the guidelines set forth in the legislation that authorized FACA. There are always negotiations and there should always be back and forth between the tribes and the governments in order to come to compromises, but there are also some things that cannot be compromised because of the way legislation was passed and how things have been signed into law. Ultimately, they want to improve the lives of Indian Country.

## Transition of Tribal Affairs from OMHD to OSLS

### Transition Overview

**Walter Williams, Director  
Office of Minority Health and Health Disparities (OMHD)  
Centers for Disease Control and Prevention (CDC)**

Dr. Williams thanked the TCAC Co-Chairs, the TCAC members, other tribal leaders in the room, CDC, and other special guests for their presence, and expressed his delight at being able to address them during this session. He said that his purpose was to formally announce the transition of tribal affairs activities, including work on CDC's tribal consultation policy and working with TCAC and related affairs, from the Office of Minority and Health Disparities (OMHD) to the Office of State and Local Readiness (OSLS). In part for him this is a celebration of many accomplishments since they began their journey together in 2005. His recollection was that CDC was the first HHS agency to establish an agency tribal consultation policy. This work began in 2004 and the policy was actually adopted in 2005. Abundant work has been accomplished since that time, including the establishment of the TCAC. In 2008, OMHD was transitioned from its position in the Office of Strategy and Innovation (OSI) to the Office of the Chief of Public Health Practice (OCPHP). That transition occurred after a transition from an office that reported directly to the CDC Director, which had been in existence for 14 years. They had to deal with some of the concerns raised throughout this meeting with respect to position within the organization, when they found themselves having to report through another person to get information and action items to the CDC Director.



With the new organizational design, OMHD has now been moved to the Office of the Associate Director for Programs (OADP), a new office established in the recent organizational redesign. In making decisions about where to place OMHD, the agency undertook a review of important functions in relation to the new proposed organizational structure. This was done through a very intensive process that took into consideration current functions, staffing, budget authority, et cetera, and asking critical questions with regard to the new CDC Director's priorities. It was determined that the tribal activities aligned best with OSLS. Most activities that are important to the programs that support Indian Country have not been affected, and others that are mission critical are continuing in other organizational components at CDC. There has been a "mixing of the bowl" so to speak, but the critical efforts to help CDC achieve its mission continue.

In September 2009, Dr. Frieden indicated that the Secretary of HHS and Congress had approved the proposed organizational improvement proposal that was submitted. Currently underway is the actual administrative process that must take place in order to officially establish all of the organizational entities. Effective January 1, 2010, it was Dr. Frieden's intent that all of the new organizational structures would be operational. Thus, CDC is currently operating under the new structure as the administrative packages move forward for final approval. Regarding the transition of responsibilities as a proponent for the CDC tribal consultation policy and work with TCAC from OMHD to OSLS, a primary focus is enhancing support for public health activities in tribal, state, and local communities. Dr. Williams said he personally perceived this as an opportunity for enhanced synergy with regard to state and tribal collaboration and enhancing state and tribal relationships. He is looking forward to Dr. White and her group moving forward with activities to make that real. He is personally looking forward to continuing to work with the CDC Tribal Liaisons. CAPT Snesrud and Dr. Bryan have been a part of his office for a number of years, so he is suffering from a little empty nest syndrome and separation anxiety that came with the knowledge that two of his valued colleagues are now moving to another office. Nevertheless, he is excited about where they are going and what portends to be a good location for enhanced action at CDC. The intent of OMHD is to continue its critical support of the critical areas in which they are partnering with TCAC to support.

### **Discussion Points**

- Mr. Antone expressed gratitude to Dr. Williams for all of his support over many years, acknowledging that he had been instrumental over the years in the ultimate foundation of the TCAC. Public health issues have made them all a part of each other, and they have continuously worked together to address issues for all tribes. He presented a beautiful vase and bowl to Dr. Williams as a symbol of how all of the tribes fit together, what the problems are, and what can be done to assist as they begin to weave strategies to move forward to hold the nations together. He indicated that the gift of the bowl and vase to Dr. Williams was to honor the efforts that he had made over the years on behalf of tribes.
- Dr. Williams thanked Mr. Antone for the gift and his gracious and kind words. He said that for him, the opportunity to come to know many of the tribal leaders, visit parts of Indian Country to see the communities first hand, and meet the tribal leaders' families members had been a very important personal journey.



- Dr. Bryan noted that he began to work for Dr. Williams in 1999, while CAPT Snesrud came on board in 2002. Over the last decade not only did Dr. Williams create their positions, but also the consultation policy endeavor ensued and the TCAC was created and established under his leadership. Dr. Bryan stressed the importance for everyone to understand the critical role that Dr. Williams and his office played in getting them to their current status. He said it had also been a personal journey for him, and he presented Dr. Williams with a gift as well. Not only is there trepidation and separation anxiety, but also there is a large degree of personal appreciation.
- Dr. Williams expressed his gratitude, noting that he was not expecting any of this. He said he really appreciated the acknowledgement of the efforts they had made through his office, stressing that it had been the results of the effort of many people. When Dr. Bryan and CAPT Snesrud came on board, it gave his office the nidus for some very important work that they pushed forward at CDC. He stressed that any successes he achieved had been on the backs of Dr. Bryan and CAPT Snesrud. He thanked them again for their kind words, but emphasized that they had been the ones who executed on many of the efforts that got them to where they were. There is still a long way to go, and he said he looked forward to their continued journey together.

### **Office of State and Local Support Welcome**

**Karen White, Acting Director  
Office of State and Local Support (OSLS)  
Centers for Disease Control and Prevention (CDC)**

Dr. White highlighted the work that had been done over the last several years in OMHD, and what that mean to CDC. Having a separation between OMHD and tribes to move into OSLS has been a long time coming. This is to be celebrated because finally tribes are being recognized as a separate entity—that tribes should be working at the same level as state and local health departments and territories versus being within an umbrella of other work at CDC. Dr. Williams has worked a very long time to help people understand, and Dr. Bryan and CAPT Snesrud have supported this endeavor over the years. The challenge of working in the administration over the last decade or so has really not permitted that to occur in a way that many at CDC believed it should. It is very important to note the immediacy with which Dr. Frieden and this administration made this change. It was very quickly on his agenda during the summer to move forward with an emphasis on states, locals, tribes, and territories. She perceived this transition as a relay in the journey that Dr. Williams discussed. This is the next step and OSLS has been charged with the obligation and responsibility to ensure that this occurs. She made a promise to those present that this would move forward, and that she, Dr. Bryan, and CAPT Snesrud had already engaged in some discussions regarding what the next steps would be immediately following this TCAC meeting. She expressed her gratitude to Dr. Williams for the work he has done to bring this program this far, indicating that she would pick up the baton and move forward from there.



## Wrap Up / Adjournment

During this session, Ms. Hughes indicated that this marked the end of the official TCAC meeting. She reminded everyone that the business left pending from the previous day was to contemplate a potential project to submit for inclusion in the 2012 CDC budget, which would be a priority for their first teleconference. The date of the first teleconference was proposed for the second Friday in February, but everyone planned to check their calendars, with a final decision to be made via email. Based on the discussion earlier in the morning, additional work needs to be done to the TCAC charter and there needs to be recognition of delegates and alternates to serve on this council.

The following subcommittees were established:

Budget	Charter
Joe Finkbonner	Joe Finkbonner
Kathy Hughes	Reno Franklin
JT Petherick	
Roger Trudell	
Derek Valdo	

The entire TCAC will be notified about these two subcommittees so that anyone who is interested may participate.

Dr. Bryan confirmed that no formal recommendations were made during this TCAC meeting, and CAPT Snesrud reminded TCAC members to submit their written reports as soon as possible. She also reminded everyone that CDC has developed its own distribution list, which will be updated at least twice a year. She requested that names be emailed to her of others TCAC members would like to be included on the distribution list.

### Discussion Points

- Dr. Tucker indicated that about four years previously, when Dr. Gerberding was the CDC Director, she and the then Secretary had a handshake deal. The Secretary had an initiative to address infant mortality, and Dr. Gerberding indicated that CDC would give IHS \$1.5 million per year to address infant mortality. The Maternal and Child Health (MCH) Director for IHS contacted Dr. Tucker to suggest that they provide MCH Epidemiologists for tribes to build capacity just as they had done for states. Thus, the funds that Dr. Gerberding awarded were allocated to the Tribal Epidemiology Centers, of which there were 7 at the time. MCH Epidemiologists were employed at these centers. Dr. Tucker said that of all of the programs she had seen in her career, this one did the most. These epidemiologists found and began collecting and analyzing data that there had never been before for local use. There began to be a liaison between states and tribes because the Tribal Epidemiology Centers could affect those liaisons and began to get the data flowing for use on the part of tribal and state governments. That project sunsetted in 2009. She hopes that some of that work will go forward, and stressed that any opportunity she gets to promote this



program, she does. She has great faith in TCAC. Some of the work that CDC can and wants to do will be accomplished because of external pressure, because tribes demand it and CDC responds to that demand.

- Ms. Hughes thanked Dr. Tucker for her comments, acknowledging that it was sometimes difficult when working on advisory councils such as the TCAC to see the progress being made. It sometimes feels that for every step forward they take two steps back. Hearing about the success stories and the improvements being made is very good.
- Mr. Finkbonner reported that John Pipe, Councilman of the Fort Peck Tribe and member of the National Diabetes Indian Coalition (NDIC), passed on January 23, 2010 having succumbed to the complications of diabetes. This brought home the efforts that the TCAC was engaged in around the table, and called attention to the public health messages and prevention programs that they want to put in place. Mr. Pipe was one of many Native Americans who have passed as a result of complications of diabetes. His passing represents a great loss for Indian Country. He was a quiet man, but there was great wisdom in the words he did speak because he chose them selectively. With that in mind, Mr. Finkbonner asked that as everyone bowed their heads to say the closing prayer they lift up Mr. Pipe, his family, and the community who lost a great leader.

*With no further questions, comments, or business posed, Mr. Antone offered the closing prayer following which the meeting was officially adjourned.*

DRAFT



## Appendix A

### CDC Tribal Consultation Advisory Committee (TCAC) Update on Recommendations/Response January 2010



#### **1. Continue to fully implement the procedures of the CDC Tribal Consultation Policy (TCP); Status: Implemented/ongoing**

The CDC/ATSDR Tribal Consultation Policy provides guidance for working effectively with American Indian and Alaska Native (AI/AN) Tribes, communities, and organizations, as well as enhancing AI/AN access to CDC and ATSDR programs. The policy identifies when CDC programs should involve Tribal leaders and outlines specific responsibilities regarding program activities, including mutual participation in setting program and budget priorities. Since the policy was released in October of 2005, both Dr. Gerberding and Dr. Frieden (CDC Directors) have supported its implementation to strengthen Tribal partnerships through increased opportunities for tribal input into CDC decision-making processes.

CDC believes this policy to be the foundation for effective government-to-government relationships. The TCP provides procedural guidance for CDC staff to ensure that more tribes and tribal organizations benefit from CDC expertise and resources by eliminating barriers and enhancing tribal access to CDC programs by assuring tribal eligibility for all CDC program announcements unless authorizing legislation and programmatic regulations restrict eligibility.

The TCP outlines several venues for tribal consultation and information exchange with CDC:

- Biannual CDC tribal consultation sessions that are open to all tribal leaders – Sessions were held on Feb. 28, 2008; Nov.20, 2008; Aug. 12, 2009, and one is planned for Jan. 28, 2010.
- Establishment of the CDC Tribal Consultation Advisory Committee (TCAC) – done Nov. 2006
- Ongoing CDC participation in HHS-sponsored national/regional tribal consultation sessions – CDC leadership has participated in each HHS national session and a majority of regional consultations since their inception
- Other requested meetings between the CDC Director (or designee) and elected tribal leaders (or their designees) – some examples of meetings that have occurred:

2007

- OSH met with Muscogee (Creek) Nation; Cherokee Nation; Aberdeen Area Tribal Chairmen's Health Board; California Rural Indian Health Board; Intertribal Council of Michigan; Big Pine Band of Paiute during April and Nov. 2007 to gain information to enable CDC to more fully understand approaches, measures, and tools for promoting tobacco cessation efforts among AI/ANs and next steps to be taken in prevention efforts.



- Native Diabetes Wellness Program, Division of Diabetes Translation, met with representatives from across the 12 IHS areas through the IHS National Tribal Leaders Diabetes Committee twice each in 2007 through 2009 about CDC's ongoing diabetes projects (including the Eagle Books) and the development of a new Funding Opportunity Announcement, "Using Traditional Foods and Sustainable Ecological Approaches to Promote Health and Prevent Diabetes in American Indian and Alaska Native Communities."
- In collaboration with CDC's Global Health Odyssey Museum and the Native Diabetes Wellness Program, the TCAC participated in an opening reception for the first exhibit of the original art work, "Through the Eyes of the Eagle: Illustrating Healthy Living for Children", October 12, 2006-January 5, 2007. The exhibit has since traveled to the Smithsonian National Museum of the American Indian and is traveling to other native and non-native venues through 2012.

## 2008

- The Native Diabetes Wellness Program responded to a thoughtful question by TCAC leadership in 2008 about the relationship of the program with the Special Diabetes Programs for Indians (SDPI) administered by IHS. Program leaders responded that our mission seeks to complement the ongoing work and respect traditional knowledge about health in tribal communities, working closely with our federal partners. The Eagle Books represent a collaborative effort used by many SDPIs and these are distributed through the warehouse of the IHS Division of Diabetes Translation, along with resources for the "Health is Life in Balance" K-12 Diabetes Education in Tribal Schools curriculum, led by NIH. Plans for the "Traditional Foods" FOA were described, with hopes of funding approximately 10 tribes or tribal organizations to further their efforts to restore local, traditional foods in their communities. The program awarded 11 tribal grantee partners in 2008, and with the assurance of continued financial support through IHS and the DDT, funded an additional six in FY2009 for a total of 17 funded partners in the Traditional Foods cooperative agreement.
- CDC Leadership met with 6 Tribal leaders from Tohono O'odham Nation in Jan. 2008 to consult about budget allocations, communication, marketing, public health capacity, environmental public health, STEP, diabetes, cancer, tobacco, STD & HIV infection, and public health emergency preparedness activities.

## **2. Assure adequate staff and resources are available within the Office of the Director (OD) to support TCP implementation. Provide OD support for Senior Tribal Liaisons (STLs) in implementation of their roles, responsibilities, and scopes of work; Status: Partially implemented/in transition**

The Office of the Director (OD) manages and directs the activities of the CDC; provides overall direction to, and coordination of, the scientific/medical programs of CDC; and provides leadership, coordination, and assessment of administrative management activities.

CDC's Senior Tribal Liaisons (STLs) have been part of the Office of Minority Health and Health Disparities (OMHD), Office of the Chief of Public Health Practice (OCPHP), Office of the CDC Director. The CDC STLs continue to provide leadership and subject matter expertise needed to help monitor progress and ensure agency-wide adherence to the TCP.





- OMHD has been the administrative base for CDC's two STLs who, along with OMHD Director, Dr. Walter Williams, were designated by the CDC Director to be the primary agency points of contact for tribal affairs.
- STLs are knowledgeable about the agency's programs and budgets, have ready access to senior program leadership, and are empowered to speak on behalf of the agency for AI/AN programs, services, issues, and concerns. Position descriptions were written (2007) and have directed the work of these Liaisons.
- The OD/National Center of Environmental Health and Agency of Toxic Substances and Disease Registry recruited and hired an experienced & knowledgeable environmental public health professional to be the primary point-of-contact for environmental health issues. (2008)
- CDC strives to manage our fiscal and personnel resources in a manner that maximizes impact on the health and safety of AI/AN people, accurately monitor resources allocated to benefit AI/AN communities, and make this information readily available to tribal leaders annually.

CDC's ability to implement effective management of activities with AI/ANs tribes depends upon an appropriate balance of staff and resources within the OD. In FY 2008, Dr. Stephanie Bailey, Chief of the Office of Public Health Practice (OCPHP), submitted a request to the OD to establish an Office of Tribal Affairs (OTA) in the CDC Office of the Director with staff increases as budget constraints allowed.

During FY 2009 and continuing in FY 2010, CDC embarked upon a major Organizational Improvement (OI) process to better support CDC priorities and operate more efficiently.

- As part of that OI process, the OCPHP no longer exists, and the STL positions will become part of the new Office of State and Local Support (OSLS). "State and local" in this context is inclusive of Tribal and Territorial governments and communities. Proposed critical functions for OSLS include:
  - Provide guidance, strategic direction and oversight for the investment of CDC resources and assets in local<sup>1</sup> public health agencies
  - Develop and oversee a cross-agency system of performance and accountability that assures that CDC resources at local public health agencies are positioned to achieve and advance the public health outcomes intended and supported by CDC
  - Strengthen local public health capacity to support the provision of programs, policies, and practice that will improve the health status of all Americans
  - Provide guidance and strategic direction for the recruitment, development and management of field staff provided to local public health agencies by CDC direct assistance (DA) funding
  - Enhance shared leadership of public health policy and practice with local public health agencies through increased collaboration and communication
- As the OI process continues, CDC leadership has committed to the establishment of an appropriately staffed and funded organizational unit within OSLS that is devoted to Tribal public health. CDC's STLs are closely involved in the planning for this unit.

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<sup>1</sup> "Local" refers to state, local, tribal, and territorial public health agencies



**3. Assure that CDC Director and other executive leadership respond in a timely and effective manner to the recommendations made by TCAC; Status: Partially implemented/in transition**

See Organizational Improvement (OI) summary in #2 above. As part of the OI process and establishment of a new organizational unit for AI/AN program activities within OD, new procedures and lines of communication will be established to maintain timely and transparent responsiveness to TCAC recommendations. Past procedures, primarily written and verbal reports to Tribal leadership during TCAC and Biannual Consultation meetings, will continue as well. In addition, CDC's Annual Tribal Consultation and Budget Report contains comprehensive fiscal and programmatic information regarding CDC's many activities to address public health issues in Indian country. That Report is also made available, separate from the HHS report, to Tribal leaders/stakeholders via posting on CDC websites. At the January 2010 CDC Biannual Tribal Consultation Session, this Report will be included in participants' meeting package.

**4. Expand efforts to ensure that funds currently awarded to state health departments through CDC cooperative agreements are appropriately benefiting American Indian Alaska Native (AI/AN) people in those states; Status: Implemented/ongoing**

Official policy to support this recommendation was established in 2005 with the release of CDC's Tribal Consultation Policy, which includes language specific to this recommendation:

- "Project officer responsibility in such cases includes ensuring appropriate benefit to AI/AN populations from CDC funds awarded to states . . . Documentation of this benefit should be included in awardees' reports required under cooperative agreements. Further, if tribal populations are included as justification in a state's grant application, states must provide documentation that tribes were involved in the development of that application and will be involved in the proposal's implementation. Also included in this responsibility is an overall effort to help serve as a "bridge" between states and AI/AN governments and organizations and to inform state colleagues about federal protocol for working with AI/AN communities, about concerns expressed, and about approaches suggested by the CDC TCAC."

Since that time, three of CDC's major funding streams to state health departments have implemented procedures in support of this recommendation: Public Health Emergency Preparedness (PHEP)/Public Health Emergency Response (PHER) awards; Immunization Grant Program (Section 317) funds; and STD control program funds awarded to states from NCHHSTP. All have implemented guidance to state awardees requiring tribal engagement/partnerships. These procedures will serve as models for other CDC programs so that similar approaches are used across all major funding awards to states from CDC.

**5. Provide authoritative guidance within funding opportunity announcements (FOAs) on how states should work with tribes, specifically requiring that applicants who use tribal populations to justify proposals document tribal involvement in both design and implementation of proposed activities; Status: Implemented/ongoing**

See #4 above and existing clause in CDC's Tribal Consultation Policy. In addition, the CDC Procurement and Grants Office (PGO) has issued guidance across CDC specifying that "CDC substantial involvement" activities for funded programs include fostering outreach and specifying goals for reaching AI/AN populations. In November 2009, PGO templates for all CDC Funding



Opportunity Announcements (FOAs) were updated to reflect these and other requirements relevant AI/AN populations for FOA applicants/awardees.

Guidance for state awardees regarding CDC expectations for working with tribal partners is now commonplace in many FOAs, for example:

- “As with previous PHER awards, CDC expects that a significant portion of the funds will be distributed and utilized at the local and tribal level.”

In addition, other CDC programs are taking proactive steps to support state-tribal cooperation:

- In August 2008, the CDC Native Diabetes Wellness Program (NDWP) launched a new initiative to encourage and support working relationships between state programs and the respective tribal nations in each State. Initiative has support from CDC’s TCAC and the Tribal Leaders Diabetes Committee. Partnerships include all state programs with an initial emphasis on “model” programs demonstrating innovation in their relationships with tribal partners and tribal nations. State-based programs have received guidance to seek opportunities for tribal consultation with tribes in their states.
- In 2009, the NDWP presented on several occasions to Division of Diabetes Translation staff, as well as to the state Diabetes Prevention and Control Program Directors, implementing elements of the NDWP State-Tribal relationship initiative. In August 2009, Traditional Foods cooperative agreement partners responded overwhelmingly their desire to meet with respective state Diabetes Prevention Control Program coordinators.

**6. Implement standardized language for CDC Funding Opportunity Announcements (FOAs) that specifies tribal eligibility unless precluded by authorizing language, single eligibility approval, or similar contingencies; Status: Implemented**

Standardized tribal eligibility language was established during FY2007-2008 and since then the PGO Technical Information Management Section (TIMS ) has monitored new FOAs (both non-research and research) to ensure compliance with tribal eligibility guidance. Tribal eligibility is specified as follows:

- Federally recognized or state-recognized AI/AN tribal governments
- American Indian/Alaska Native tribally designated organizations
- Alaska Native health corporations
- Urban Indian health organizations
- Tribal epidemiology centers

**7. Increase tribal stakeholders’ knowledge of CDC Funding Opportunity Announcement (FOA) and how to obtain TA during the grant application process; assist TCAC in establishing a technical subcommittee to evaluate how FOAs and the grant application process could be modified to encourage more tribal applicants and to help ensure that tribal applicants have equal opportunities to compete successfully; Status: Implemented/ongoing**

CDC utilizes cooperative agreements and grants to assist other health-related and research organizations that contribute to CDC’s mission of health promotion through health information dissemination, preparedness, prevention, research, and surveillance.



Through various mechanisms (e.g., emails, meetings, web postings) CDC has informed Tribal leaders and other AI/AN stakeholders about information available on the PGO website: [http://www.cdc.gov/od/pgo/funding/grants/faq\\_main.shtml](http://www.cdc.gov/od/pgo/funding/grants/faq_main.shtml)) -- information that supplements that available at [www.grants.gov](http://www.grants.gov). The PGO website provides useful information on finding and responding to CDC FOAs. Most awards are made through a competitive application process; however, if either Congress or CDC determines that a single organization is the best resource for the public service activity, a grant may be awarded without competition.

PGO has committed to increased outreach activities and training sessions for AI/AN tribes, tribal organizations and stakeholders as funding permits. Recent examples include training and technical assistance sessions in conjunction with CDC TCAC Meetings and Biannual Tribal Consultation Sessions in July 2008 (Florida); November 2008 (Arizona), and August 2009 (Alaska).

**8. Within selected CDC programs, explore the possibility of designating a certain proportion of cooperative agreement funds as intended for tribes/tribal organization as awardees. Involve TCAC in discussions across Centers on expanding these approaches; Status: Implemented/ongoing**

Several CDC programs currently allocate funds in this manner and the approaches taken by these programs are shared across CDC. Examples include the following:

- The Division of Cancer Prevention and Control (DCPC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funds 12 AI/AN tribes/tribal organizations and two National Tribal Organizations. DCPC also funds 7 Tribal Comprehensive Cancer Control Programs and 4 Tribal Colorectal Cancer Screening Programs.
- Under the REACH US Program, CDC awarded six entities targeting the elimination of health disparities in Native communities; all are fully engaged in intervention activities. Two of these entities (OK State Department of Public Health; University of Colorado at Denver) are functioning as Centers of Excellence for the Elimination of Health Disparities (CEED) and serving as resource centers on effective interventions in addition to working in their “home” communities.
  - Four entities (Choctaw Nation of OK; the Eastern Band of Cherokee Indians; the Inter-Tribal Council of Michigan; the Northern Arapaho Tribe) are funded as Action Communities; they are implementing and evaluating successful approaches for eliminating health disparities in tribal communities.
- The Division of Diabetes Translation (DDT) Native Diabetes Wellness Program (NDWP) released an FOA to tribes/tribal organizations for 5-year cooperative agreements to support community use of traditional foods and sustainable ecological approaches for diabetes prevention and health promotion in AI/AN communities. The funded programs engage communities in identifying and sharing the stories of healthy traditional ways of eating, being active, and communicating health information and support for diabetes prevention and wellness.
  - From a pool of 60 AI/AN applications, 11 cooperative agreements were awarded in 2008, with an additional six in FY 2009 to tribes/tribal organizations across the nation at approximately \$100,000 each per year for a total of \$1.7 million per year through FY 2013.
- CDC’s Office on Smoking and Health funds seven tribes/tribal organizations. In November 2009, during a meeting initiated by the Black Hills Center for American Indian Health



(BHCAIH) and co-sponsored by CDC, NACCHO, and NALBOH, the Navajo Nation Division of Health announced it will take the lead on efforts to pass strong comprehensive clean air legislation and provide leadership for the Navaho Nation's tobacco control and prevention efforts.

- CDC's Office on Smoking and Health also funds the National Native Commercial Tobacco Abuse Prevention Network. OSH and the national network are collaborating on a series of trainings tailored for tribes who wish to implement their own AI/AN Adult Tobacco Survey.
  - The training stresses the importance of tribal-specific surveillance in informing and improving comprehensive commercial tobacco prevention and control at the tribal health system level and provides the knowledge and tools that allow tribes to implement this surveillance system.
  - Tribes served by the Inter-Tribal Council of Michigan, the Aberdeen Area Tribal Chairmen's Health Board, Muscogee (Creek) Nation and the Tribal Support Centers for Tobacco Programs are committed to work collaboratively on these trainings that will be held at least twice per year. Ongoing technical assistance for tribes in the area of surveillance implementation and data analysis will also be provided.

**9. Provide culturally appropriate training for project officers assigned to States with established AI/AN communities; Status: Implemented/ongoing**

During the past few years, multiple programs at CDC, such as the Division of Cancer Prevention and Control, the Office on Smoking and Health, the Division of Diabetes Translation, the Division of Unintentional Injuries, the Division of STD Prevention, and the Office of Workforce Development have regularly offered training opportunities for new project officers and training in additional competencies for all project officers (Atlanta and state-based). Content specific to tribal relationships, TCP, etc. is included in these trainings.

**10. For competitive applications responsive to AI/AN-focused program announcements, seek objective review panel members who are knowledgeable about working with AI/AN communities; Status: Partially implemented/efforts ongoing**

PGO has committed to working assertively with all CDC programs to ensure that, whenever possible, AI/AN professionals and/or others with subject matter expertise and experience in Indian country serve as objective review panel members and chairs of objective review panels. An agency-wide data base listing individuals with knowledge and skills of this type is planned, but not yet completed.

**11. Assist in the orientation of TCAC members and other tribal leaders to CDC and ATSDR by developing and distributing a directory of CDC and ATSDR services and resources; Status: Implemented**

CDC leadership and staff have offered a "Tribal Leaders Orientation to CDC" at the past two Atlanta-based Biannual Tribal Consultation Sessions (2008 and 2010).

The CDC publication "Rx for Health," which explores the wealth of informational products and services that CDC offers, was distributed at the Biannual Tribal Consultation Session in Atlanta in February 2008 and posted on the National Indian Health Board (NIHB) website. It is accessible here also: [http://www.cdc.gov/about/stateofcdc/pdf/rx\\_for\\_health2008.pdf](http://www.cdc.gov/about/stateofcdc/pdf/rx_for_health2008.pdf)



CDC Divisions and funded Tribal Programs have been sharing “best practices” at the NIHB Public Health Summit, the NIHB Annual Consumers Conference, the IHS Health Summit, and at multiple CDC sponsored conferences and Grantee Meetings for state funded programs to help inform all public health partners of effective practices.

“The State of CDC” found at <http://www.cdc.gov/about/stateofcdc/> has been distributed annually. This report goes behind the scenes with the nation's premier public health agency to explore stories of health protection, cutting-edge research, and real-world disease investigation that CDC is conducting every day. In addition CDC has also made other publications available to help stakeholders understand more about CDC. These publications include:

- [Public Affairs in Health \(PAH\)](#)  
Public Affairs in Health (PAH) is a peer-reviewed electronic journal established to provide a forum for public affairs professionals working in public health to share study results and practical experience. The journal is published by the Office of Enterprise Communication within CDC. PAH is published biannually in April and October. Articles published in PAH include editorials, essays, original research reports, best practices, milestones in public health (MPH), and announcements.
- [Pandemic Influenza Storybook](#)  
This year marks the 90th anniversary of the 1918 influenza pandemic. That pandemic killed more than 50 million people worldwide including an estimated 675,000 people in the United States. The stories related in the Pandemic Influenza Storybook will make you cry, some will make you laugh, but all serve as reminders of the primary reason why preparedness is so important — saving human lives. This first edition contains 50 stories from 26 states.
- [CDC: 60 Years of Excellence](#)  
A look at CDC's 60 Year Legacy of Excellence in protecting the health of the public.

**12. Continue discussions with CDC's Financial Management Office (FMO) to establish guidelines and a timeline to allow tribal stakeholders to provide annual input into the CDC budget formulation process. Monitor and track where tribal recommendations have influenced CDC priorities and goal process, and have enhanced tribal access to CDC resources; Status: Partially implemented/efforts ongoing**

The FMO Deputy Director and/or designee have regularly attended CDC TCAC meetings and Consultation Sessions to brief TCAC and other tribal leaders on the CDC budget and budget formulation process.

- FMO has advised the TCAC that a FMO designee will serve as a resource to the TCAC Budget Subcommittee to answer questions and increase transparency for Tribes in order to assist them in providing concrete recommendations to CDC about budget allocations and formulation.
- Beginning in 2005, FMO has worked closely with OMHD to prepare the CDC Annual Tribal Budget and Consultation Report each December. Along with this comprehensive budget, FMO annually develops a slide deck to compare and contrast overall agency categorical allocations with those specific to AI/ANs.

**13. Re-analyze the CDC AI/AN Resource Allocation Portfolio such that resource allocations are: a) stratified by categorical programs that are of high priority to Indian country; and, b) stratified geographically; Status: Implemented/ongoing**



During the FMO briefings to tribal leaders, FMO provides a comprehension breakdown of CDC allocations benefiting tribes by state, IHS Areas, and HHS Regions. CDC strives to manage its fiscal and personnel resources in a manner that maximizes impact on the health and safety of AI/AN people, accurately monitor CDC resources allocated to benefit AI/AN communities, and make this information readily available to tribal leaders.

- CDC is using a portfolio management approach to its resources devoted to AI/AN health issues. This approach improves how CDC tracks and displays its AI/AN resource commitments and enables CDC to more closely monitor funds distributed to state health departments via CDC grants and cooperative agreements to help ensure that AI/AN communities receive appropriate benefit from these funds.
- In FY 2009, total funds allocated through competitively awarded grants and cooperative agreements to tribal partners approached \$24 million (\$23,854,212). Compared to FY 2008, total funding in this category increased in the amount of \$1,014,698 or 4 percent.
- CDC estimates its total FY 2009 resource allocation for AI/AN program to be approximately \$168 million. The total figure (\$167,637,959) represents a 55 percent increase compared to AI/AN allocation in FY 2008, an increase that is consistent with an overall increase in VFC funds received by CDC in FY 2009. If VFC funds are not included, CDC estimates its total FY 2009 allocation for AI/AN programs to be \$45 million, 53 percent of which goes directly to tribal partners and 76 percent overall is expended outside of HHS<sup>2</sup>. The total figure (\$45,371,807) represents a 4 percent increase over non-VFC AI/AN allocations in FY 2008.

**14. Develop a CDC-wide AI/AN action plan that will strategically integrate AI/AN – focused policies, resources, and programs; align these activities with CDC’s Health Protection Goals; and serve as a roadmap and portfolio management tool for CDC’s overall efforts to optimally impact the public health of AI/AN people and communities; Status: Not implemented**

Although this recommendation has been discussed within CDC OD during past administrations, no definitive action has taken place thus far. It is anticipated that this recommendation will be given due consideration under new CDC leadership and as the Organizational Improvement process moves forward in FY 2010.

**15. Reconsider recent decisions regarding funding for HIV and STD prevention programs in Indian country; Status: Implemented (reconsidered in 2007). Again in 2009, AI/AN Tribes have requested CDC to reconsider funding decisions for HIV/AIDS. /Activities are being implemented in response to this.**

Dr. Gerberding received a letter from the Northwest Portland Indian Health Board (NPAIHB) requesting reconsideration regarding funding of the Red Talon Project during FY 2007. Dr. Gerberding responded to NPAIHB on January 17, 2007.

CDC remains committed to developing and supporting culturally-specific best practices that effectively and appropriately address HIV and STD prevention in diverse Native communities. NCHHSTP will continue to support national initiatives like the annual Native AIDS Awareness Day and other National HIV/AIDS AI/AN conferences. NCHHSTP supports HIV and STD prevention programs in Indian country in a variety of ways:

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<sup>2</sup> Extramural and Direct funds



- NCHHSTP funds Tribes and organizations that successfully compete for FOA awards (9 in 2007; 10 in 2008; and 8 in 2009).
- In addition to the direct awards to tribes and tribal organizations, NCHHSTP also had maintained an Interagency Agreement (IAA) with IHS supported by the Division of Sexually Transmitted Diseases Prevention (DSTDP).
  - This IAA supports two senior public health staff assigned to the IHS Division of Epidemiology to maximize resources and collaborations across Indian country.
  - DSTDP plans to maintain this IAA to support and enhance STD prevention and control efforts in AI/AN populations. This IAA assists DSTDP to raise awareness of STDs among AI/AN as a priority health issue, supports partnerships and collaborations with multiple public health partners (state STD programs, IHS, tribal, and urban Indian health programs (I/T/U), and support improvement of STD programs for AI/ANs.
  - The IAA has also supported STD outbreak response efforts and integration of STD, HIV/AIDS, TB, and hepatitis prevention and control activities. The DSTDP has funded ANTHC to assess the acceptability, feasibility, and impact of self-collected specimens on reducing barriers to health-care-seeking behaviors and increasing STD screening opportunities among Alaska Natives in both rural and urban settings.
- For two successive years, the NCCDPHP/Division of Reproductive Health (DRH) successfully competed for Minority AIDS Initiative funds from HHS Office of HIV/AIDS Policy and are using monies from this funding stream to focus on adapting training and technical assistance tools for providers of AI/ANs. Pilot projects are underway in CA and AK.
- CDC/IHS National STD Program provided funding to the IHS Bemidji Area Office (BAO) who partners with the Great Lakes Inter-Tribal Epi Center (GLITEC) to provide mini-grants to one tribe or tribal organization in each of the three states of Michigan, Minnesota, and Wisconsin to work on local needs. .
  - Collaborations and technical assistance will be provided as they work with tribes and tribal organizations to complete their projects.
  - DSTDP is also partnering with IHS, Project Red Talon, and Mercer University School of Medicine in a project called Native Students Together Against Negative Decisions (NativeSTAND)—a peer education curriculum for healthy decision-making for Native youth.
- Since 1989, CDC has funded the National Native American AIDS Prevention Center (NNAAPC) to provide capacity building assistance (CBA) to organizations providing services to AI/ANs nationwide.
  - With these funds, NNAAPC provided CBA to CBOs and health departments serving Native populations, emphasizing the integration of Native principles, beliefs, and communication styles into HIV prevention activities.
- Just recently under a new FOA, NCHHSTP funded two non Native organizations to strengthen organizational infrastructure, interventions, strategies, monitoring and evaluation for HIV prevention, to deliver CBA to community-based organizations serving all high-risk and racial/ethnic minority populations, including Native communities.
- In addition, NCHHSTP also funded two other organizations, Aberdeen Area Tribal Chairmen's Health Board (AATCHB) and Colorado State University to focus on strengthening community access to and utilization of HIV prevention services in Native communities.
  - AATCHB will provide culturally appropriate CBA to tribal HIV and STD prevention personnel on reservations and urban centers in Colorado, Iowa, Illinois, Indiana, Kansas, Minnesota, Michigan, Missouri, Montana, North Dakota, Nebraska, Ohio, South Dakota, Utah, Wisconsin, and Wyoming to reduce health disparities currently existing for AI populations.





- Colorado State University will continue to strengthen the capacity of CBOs serving Native people to develop and implement regionally specific and community-specific strategies to address HIV/AIDS

**16. Strengthen the relationship between the Division of Adolescent and School Health (DASH) and tribal stakeholders to maximize resources and opportunities to address issues facing AI/AN youth; Status: Implemented**

Following meetings between DASH staff and the CDC TCAC, DASH convened an internal working group to identify collaborative strategies and activities for working more effectively with Tribes. In FY 2007, for the first time in DASH history, Tribes were included as eligible applicants for the Coordinated School Health FOA.

- Three tribes (Cherokee Nation, Nez Perce Nation, and the Winnebago Tribe of Nebraska) were funded in FY2008 and other State Education Programs are now reaching out to tribes and working collaboratively with them in the development and implementation of programs benefiting AI/ANs in their school districts.
- On an ongoing basis, DASH's Surveillance and Evaluation Research Branch provides technical assistance to the Bureau of Indian Education and the Navajo Nation to conduct the Youth Risk Behavior, which is conducted every 3 years to collect data on students in Bureau-funded schools to determine the prevalence of health-risk behaviors and assess trends in these behaviors to more effectively target and improve programs.

**17. Bring SAMHSA and CDC leadership together to consider programming in Indian country with an agenda to increase investment in Suicide Prevention and other priority issues where there might be strengthened outcomes by collaborative work; Status: Implemented/ongoing**

During FY 2008, the CDC Adolescent Health Goal Team prioritized the need to explore further suicide prevention activities in AI/AN and Hispanic/Latino youth. DASH, along with the National Center for Injury Prevention and Control (NCIPC)/Division of Violence Prevention, multiple divisions from within NCCDPHP, and OMHD participated in an internal day long session on how to use the limited CDC funds available to address this issue.

- CDC along with SAMHSA and HIS convened a meeting in Washington, DC over September 21 – 23, 2009 wherein subject matter experts met to assess topics such as prevalence, risk and protective factors, prevention strategies, policy and legal implications, and dissemination needs. The group identified knowledge gaps, research and program needs, and key recommendations. Findings from this meeting of experts have been synthesized and will help to inform next steps in addressing suicide in Indian country. As recommended by the CDC TCAC, several Native youth did participate in the meeting. Proceedings from this meeting will be shared with TCAC and Tribal leaders broadly as soon as available.
- The Native Diabetes Wellness Program, together with SAMHSA, has made available a reprint of the "Guide To Build Cultural Awareness – American Indian and Alaska Native", for distribution nationwide through SAMHSA, CDC, and the Indian Health Service. SAMHSA secured HHS clearance, and CDC provided funding and printed 115,000 cards, which were delivered to SAMHSA in March 2009. To date, requests are coming in for at least 6,500 cards per month.



**18. Work together with tribes and tribal organizations to ensure AI/AN Tribes are included in the planning of public health emergency preparedness activities and events to assure a coordinated and effective public health response; Status: Implemented/ongoing**

CDC has been working to strengthen federal/state/tribal relationships such that tribal governments and organizations have access to funds awarded to the states (e.g., see Recommendations #4 and #5 above). Highlights of multiple efforts across CDC to respond to this recommendation include:

- Since the beginning of the Public Health Emergency Preparedness (PHEP) Cooperative Agreement program, many states have worked with tribal organizations in improving preparedness. Tribal participation, including receipt of resources from states, has been encouraged and expected; over the past 3 years tribal concurrence with statewide preparedness plans and activities has been required.
- Beginning in FY07, there has been a requirement in the CDC PHEP program guidance that promotes tribal engagement. A letter from either the individual tribes within a state's boundaries, or an appropriate tribal health board or tribal leaders' coalition representing those tribes, is required. The letter specifies that the tribes or their legitimate representatives have been engaged in planning, and are in substantial agreement with the plan and the methodology for distributing Cooperative Agreement funds across a given state. This language included in the guidance was developed with the assistance of the CDC Tribal Consultation Advisory Committee.
- Each year the Division of State and Local Readiness (DSLRL) conducts a state-by-state review of PHEP Continuing Applications, monitors for Tribal inclusion, concurrence, involvement in planning, and implementation of activities. They share research and information on Tribal Capacity and Tribal Preparedness Plans at annual grantee meetings.
- Awardees for the CDC Centers for Public Health Preparedness (CPHP) program host national and regional conferences that provide an effective forum for discussing preparedness-building activities and opportunities for establishing collaborative capacity-building activities among and between tribal, state, and local governments and other agencies. The conferences are intended to stimulate the sharing of ideas, resources, and information on public health capacity building as a way to enhance public health preparedness programs that target and involve tribal people.
- CDC's Division of Strategic National Stockpile (DSNS) sponsored a webcast entitled: Mass Antibiotic Dispensing-Partnering with Tribal Governments and Communities. The broadcast is archived on the CDC website for current viewing. Continuing Education Credits are available to viewers of the broadcast through March 3, 2012.
- DSNS, in partnership with OMHD/OD/CDC and IHS, developed a brochure: *Preparing Tribal Nations to Receive Strategic National Stockpile Assets*. This brochure is available here: [http://www.cdc.gov/h1n1flu/pdf/preparing\\_tribal\\_national\\_stockpile.pdf](http://www.cdc.gov/h1n1flu/pdf/preparing_tribal_national_stockpile.pdf)
- In December 2009, 55 tribal communicators from 29 unique tribes across the United States participated in this training course. The CERC/Pandemic Influenza course is a 1½ day training that offers a combination of influenza communication tabletop exercises and informative group discussions. CERC is an approach used by scientists and public health professionals to provide information that allows an individual, stakeholders or an entire community, to make the best possible decisions about their well-being, under nearly impossible time constraints, while accepting the imperfect nature of their choices. The CERC training program draws from lessons learned during public health emergencies, and



incorporates best practices from the fields of risk and crisis communication. With this comprehensive training program, the CDC has moved forward in meeting the needs of partners and stakeholders in preparing for, responding to and recovering from the threat of bioterrorism, emergent diseases, and other hazards.

- This training session was the third to be offered specifically to tribal communicators. The first CERC training course for communicators to tribal nations was held April 10-11, 2007 in Phoenix, Arizona and the second was held in San Antonio over October 29-31, 2007. During the December 2009 training session, tribal attendees took part in the CERC "Basic" and "Pandemic Flu" training modules. In addition, all attendees participated in a tabletop exercise based on the current H1N1 pandemic. Because this training session took place in Atlanta, a number of participants took advantage of an opportunity to tour the CDC Global Health Odyssey Museum (<http://www.cdc.gov/gcc/exhibit/default.htm>) and the CDC Emergency Operations Center (<http://emergency.cdc.gov/cotper/eoc/>). For more information on CDC's CERC program and access to on-line training modules, please visit: <http://emergency.cdc.gov/cerc/index.asp>.

CDC's ongoing efforts address emergency preparedness and response in Indian country is exemplified by the multiple activities recently implemented in response to the 2009 H1N1 influenza pandemic.

- To develop, facilitate, and coordinate many of these activities, CDC established an AI/AN Populations Team (AAPT) in the CDC Emergency Operations Center (EOC), co-led by the CDC Senior Tribal Liaison for Science and Public Health and the Director of CDC's Arctic Investigations Program. AAPT activities have included:
  - Technical assistance to the Indian Health Service (IHS), including an evaluation of the IHS Influenza Awareness System (IIAS) confirming its high sensitivity and specificity for detecting influenza-like illnesses (ILI)
  - Support for the publication and dissemination of the MMWR article documenting increased H1N1-death rates among AI/AN: [http://www.cdc.gov/h1n1flu/statelocal/keyfacts\\_deaths.htm](http://www.cdc.gov/h1n1flu/statelocal/keyfacts_deaths.htm)
  - Confirmation of increased rates of Alaska Native hospitalizations due to H1N1
  - Raising and maintaining awareness of CDC leadership in regard to the impact of H1N1 on AI/AN populations
  - Establishing a dedicated section of CDC's H1N1 website for information of importance to Tribal Health Officials: <http://www.cdc.gov/h1n1flu/statelocal/>
  - Production of video and radio PSAs with AI actor, Wes Studi: [http://www.cdc.gov/h1n1flu/statelocal/aian\\_psa.htm](http://www.cdc.gov/h1n1flu/statelocal/aian_psa.htm)
- Other tribal-related H1N1 activities at CDC have included:
  - Disseminating H1N1 information directly to tribal constituents and stakeholders, including IHS, via web postings and direct e-mail distribution
  - Providing updates to tribal leadership on H1N1 during national and regional tribal consultation meetings, NIHB Annual Consumers Conference, NCAI, and the CDC Consultation Session in Anchorage, AK over August 11-13, 2009
  - Working with states and tribal governments to ensure tribal benefit from federal funding streams intended to support H1N1 preparedness and response.
  - Published an article on vulnerable populations in tribal communities in the American Journal of Public Health



- Developed, in partnership with IHS, a guidance document on H1N1 issues in Indian country that accompanied a letter from Secretary Sebelius to Tribal leaders:  
[http://www.cdc.gov/h1n1flu/statelocal/DTLL\\_H1N1\\_Guide\\_10-7-09.pdf](http://www.cdc.gov/h1n1flu/statelocal/DTLL_H1N1_Guide_10-7-09.pdf)
- Posted useful legal documents on CDC's Public Health Law Program website:  
<http://www2a.cdc.gov/phlp/mutualaid/MutualResources.asp#>
- Developed, with IHS, and distributed a vaccination poster for tribal audiences:  
[http://www.cdc.gov/h1n1flu/additional\\_print.htm#nativeamerican](http://www.cdc.gov/h1n1flu/additional_print.htm#nativeamerican)

**19. CDC should consider developing a tribal training center and utilize a clearinghouse approach so that the “best practices that are being developed in CDC collaborative work with tribes” can be mimicked in other new program areas of tribal importance. CDC should share these “best practices” at upcoming AI/AN conferences to help inform and train tribal leaders and tribal health staff. CDC needs to provide more technical assistance in the public health arena so that tribes are able to implement these programs at the local level; Status: Implemented/ongoing**

Many of the responses noted above are consistent with the ‘clearinghouse’ concept and making information readily available to tribal leaders and public health officials (see particularly responses to #s1 and 11 through 18). In addition, beginning the week of January 25, 2010, CDC will release the inaugural special subject issue of its e-mail and web-based newsletter, “Knowledge to Action Science Clips,” dedicated to AI/AN and indigenous health publications. The Clips series focusing on AI/AN health will recur biannually and will highlight work/publications by CDC staff and their partners in other organizations. A more comprehensive list of publications of this type are included in CDC’s contribution to the HHS AI/AN Health Research Advisory Council (HRAC) annual report.

Other CDC activities relevant to this recommendation include:

- CDC staff served as faculty for the Summer Research Training Institute for American Indian and Alaska Native Health Professionals in Portland, OR, June 15 - July 2, 2009. The Institute curriculum is designed to meet the needs of professionals who work in diverse areas of American Indian and Alaska Native health...from administrators to community health workers, physicians, nurses, researchers, program managers...almost anyone who works in Indian health care and wants to take advantage of new skill-building opportunities. Because our courses emphasize research skills and program design and implementation, those professionals who seek training opportunities related to research will find relevant courses in this program.
- In FY 2008, CDC staff addressed racial misclassification, a major barrier to accurate AI/AN cancer data, by conducting linkages, at low cost, between the IHS patient registration database and central cancer registries in all states. CDC staff led efforts to publish “*Annual Report to the Nation on the Status of Cancer, 1975–2004, Featuring Cancer in American Indians and Alaska Natives*” in the October 2007, journal *CANCER*.
- In February 2008, CDC center leadership met with representative of NIHB and Tribal Epi Centers to educate and establish a relationship and identified points-of-contacts to periodically share information about public health activities and initiatives.
- In May 2007 (Anchorage, AK), 20 participants from tribal governments, Tribal EpiCenters, tribal health boards, Alaska Native health corporations, and the NIHB met with 21 other participants of state, and federal public health professionals and consultant legal experts to discuss the current status of public health legal preparedness in Indian country, identify



gaps in public health legal foundations, and develop an initial plan of action to address these gaps.

- CDC in consultation and collaboration with Northwest Portland Area Indian Health Board/Project Red Talon; participating schools, tribes, and health care facilities; corporate partners Beckton Dickson and GenProbe, and IHS STD staff worked together to implement school-based STD screening in schools serving AI/ANs.
- CDC NCBDDD in collaboration with SD Department of Health, University of SD, ND Fetal Alcohol Syndrome Center met with American Indian communities in Standing Rock, Turtle Mountain, and Pine Ridge to develop a media campaign to promote a community-based intervention for women of childbearing age to either reduce their drinking or to improve family planning.

**20. Strongly recommend that NIHB hold a “CDC Day” at their annual conference, or highlight CDC in the morning and another agency in the afternoon. Simply having the Public Health Summit does not create the visibility needed for tribes to understand CDC and what it has to offer AI/AN tribes; Status: Not implemented/other activities apply**

CDC has communicated to NIHB our interest in supporting a “CDC Day” at their Annual Consumer’s Conference. In the meantime, CDC professionals and leadership have continued to participate in numerous regional and national tribal meetings – prominent examples include: NIHB Public Health Summit, NIHB Annual Consumer’s Conference, IHS Public Health Summit, Tribal Epicenters Meetings, Association of American Indian Physicians Annual Conference, AI/AN Health Research Conference, National Congress of American Indians Annual Conference, and HHS Regional Tribal Consultation Sessions.

**21. Allow tribal organizations to have access to some of the expertise that CDC has as tribes develop methodologies to collect and analyze data, and develop statistical reports, it would be ideal to have an expert verify the work for flaws; Status: Implemented/ongoing**

The responses to recommendation #19 above are also germane to this recommendation. In addition to the examples already cited, CDC staff in Albuquerque, NM remains ready to assist tribal organizations as described in this recommendation. Subject matter experts (SMEs) in epidemiology, statistics, policy analysis, racial misclassification, health disparities, cancer, immunizations, and STDs work full-time on tribal health issues in close collaboration with IHS. These SMEs maintain close working relationships with a number of Tribal Epi Centers.

Similarly, CDC SMEs with the Arctic Investigations Program in Anchorage maintain ongoing and robust collaborations with many Alaska Native health organizations across Alaska. Examples of these many collaborations can be found in the annual update, “Centers for Disease Control and Prevention: Highlights of AI/AN-Focused Activities, FY 2009, *A Summary Report for the 4<sup>th</sup> Biannual CDC Tribal Consultation Session, January 28, 2010, Atlanta, GA.*”

**22. Develop an annual report that will describe recommendations that have been made within the last two years, and the status of each; Status: Implemented/ongoing**

This report, “CDC Tribal Consultation Advisory Committee (TCAC) - Update on Recommendations/Response, January 2010,” will be updated annually. In addition, the report



mentioned in response to recommendation #3 above will also be issued annually as it provides a more comprehensive overview of CDC program activities relevant to Indian country. The title of that report is, "Centers for Disease Control and Prevention: Highlights of AI/AN-Focused Activities, FY 2009, A Summary Report for the 4<sup>th</sup> Biannual CDC Tribal Consultation Session January 28, 2010, Atlanta, GA."

**23. Schedule COTPER/DSLRL project officers to present at the next TCAC meeting to address CDC state guidance policies as they related to tribes. Require states that receive PHEP funding to make a formal report to share with TCAC and other tribal leaders; Status: Implemented/ongoing**

In addition to the detailed responses outlined under recommendations #4, 5, and 18 above, COTPER Leadership and DSLR project Officers met with Tribal leaders during the February 2008 Biannual Tribal Consultation Session and again at the 2010 Tribal Leaders Orientation to CDC session, both in Atlanta.

**23. Develop a strategic budget plan to determine what options are available for FY2011 and FY2012; Status: Not implemented**

Similar to the response above to recommendation #14, no definitive action has taken place thus far. It is anticipated that this recommendation will be given due consideration under new CDC leadership and as the Organizational Improvement process moves forward in FY 2010.

**24. Gain commitment of CDC/NCEH and ATSDR to assist the Navajo Nation with environmental and pollution issues; Status: Implementation in progress**

Several activities are underway or planned that address this recommendation:

- **NCEH is assisting investigation of Drinking Water Exposures in Unregulated Water Sources at the Navajo Nation (NN).**
  - Water hauling is widespread on NN. Approximately 25% households on NN are not connected to a public water system and must haul drinking water from outside, often untreated sources. Connected households may still choose to haul water from untreated sources. The extent to which Navajo people consume untreated water has not been quantified. The exposures and health risks associated with this practice are unknown.
  - As a first step in addressing this knowledge gap, NCEH/ Health Studies Branch (HSB) conducted a study of 199 untreated water sources (livestock wells and springs) used for drinking water in the NN in August 2006 and September 2007. This study showed widespread bacterial contamination and water sources exceeding EPA limits for uranium and arsenic. The study identified 5 high risk communities where water arsenic and uranium were concentrated. In order to assess the extent of human exposure to drinking water contaminants in the 5 high risk communities, HSB also conducted a cross-sectional household study in October 2008 (see next topic). In the fall of 2009, HSB conducted additional sampling of unregulated wells that had been identified from the household survey. Sample results from these wells are pending.
- NCEH/HSB conducted a household survey of drinking water sources and contaminant exposures at the NN.
  - Cross-sectional household surveys of 296 households (with and without access to potable water) were randomly selected from five NN communities. HSB interviewed one



member of each household on water hauling practices, tested for urine biomarkers of exposure to 18 chemicals, and analyzed one drinking water sample for chemical and bacterial contaminants. Of 296 water samples collected, 34 (11%) samples exceeded safe drinking water standards for arsenic and 8 (3%) samples exceeded safe water standards for uranium. Ninety-two (35%) of the drinking water samples tested positive for total coliform and 22 (8%) tested positive for *E. coli*. Of the 244 urine samples collected, 103 (42%) had high uranium levels (>95<sup>th</sup> % of levels seen in the US population as defined by NHANES). The study population had urine levels higher than usual for national levels but comparable to other regional study levels, though none at levels known to cause health effects. Uranium contamination of water sources does not appear to be the primary cause of increased uranium levels found in urine. Bacterial contamination was found in water samples which could indicate a public health risk. In the fall of 2009, additional urine testing of participant family members was offered and conducted as a public service.

- Additional activities related to the two projects above included visiting each study participant in-person to discuss study results, presenting results at Chapter meetings and to community groups, preparing physician education for clinics in the study area to understand study results and potential health concerns, referring participants to the Indian Health Services' (IHS) screening program, and labeling unsafe water sources.
- House Committee on Oversight and Government Reform Bi-Annual Meeting to Discuss Updates Regarding the Five-Agency, Five-Year Plan to Address Health and Environmental Impacts of Uranium Contamination at the NN.
  - Since September 2008, representatives from NCEH and ATSDR have attended bi-annual meetings with congressional representatives of the House Committee on Oversight and Government Reform which is overseeing efforts to address health and environmental impacts of uranium contamination at the NN. Five federal agencies including the Environmental Protection Agency (EPA), Department of Energy (DOE), IHS, Bureau of Indian Affairs (BIA), and the Nuclear Regulatory Commission (NRC) have each been tasked with responsibilities for assessment and remediation related to uranium exposure and contamination. NCEH and ATSDR have been actively providing technical support to EPA and IHS for numerous activities related to environmental public health.
- The House Committee on Oversight and Government Reform requested that the BIA, DOE, NRC, EPA, and IHS develop a coordinated five-year plan to address the health and environmental impacts of uranium contamination in the NN. ATSDR and NCEH have participated in congressional briefings on this subject.
  - In support of the 5 agency, 5-year plan, ATSDR conducted Grand Rounds training for medical professionals at the NN. The subject of the training was uranium exposure, but also touched on arsenic in drinking water which is of concern to the tribe. The training was conducted through the Division of Toxicology and Environmental Medicine's (DTEM) cooperative agreement with the American College of Medical Toxicology (ACMT) and included technical input from the ATSDR Division of Health Assessment and Consultation (DHAC) and the ATSDR Division of Regional Operations (DRO). A physician with board-certification in toxicology was selected by ACMT to conduct the training which took place in December 2008 at four IHS clinics located in the Navajo communities of Tuba City, AZ; Kayenta, AZ; Chinle, AZ; and Shiprock, NM. The development of this training was an interdisciplinary effort with input from the IHS, EPA,



ACMT, NCEH, NN, University of New Mexico (UNM), Southwest Research and Information Center (SRIC), and others.

- On July 13-14, 2009, Community Health Representatives (CHRs) from the NN Health Clinics were provided training to prepare them to deliver individual bio-monitoring results to approximately 300 households that participated in a 2008 investigation of drinking water exposures. The drinking water study was conducted by the NCEH/HSB and the NN Environmental Protection Agency (NNEPA). The 2008 investigation focused on the extent to which non-regulated water sources represent a public health threat to members of the NN. The water study investigation protocol required that each participant be provided their individual bio-monitoring results through a personally delivered letter. ATSDR's Division of Health Assessment and Consultation (DHAC) and Division of Toxicology and Environmental Medicine (DTEM) collaborated with the HSB and the NCEH/ATSDR Office of Tribal Affairs to develop the specialized training.
  - The CHR training provided information on 1) the biomonitoring laboratory results and the potential health effects of those laboratory findings on the health of individuals who participated in the bio-monitoring study; and 2) background information on bacteria and chemical water contamination found in non-regulated Navajo Nation wells and springs that were potential threats to public health when used as a drinking water source. The third aspect of the training was to promote safe water hauling practices that included steps necessary to sanitize water containers as well as types of containers appropriate for the hauling and storage of drinking water. The training was designed to provide opportunities for the CHRs to translate the materials into Navajo. Education examples were developed that reinforced the importance of only using water from regulated wells or springs for cooking and drinking as a way to protect and improve individual and family health. A two-sided desktop flip chart was developed as a job-aid for use by the CHR's when individual results were delivered to tribal members.
  - More than 50 CHRs and NNEPA staff participated in the 2-day workshop. The CHRs were then better prepared to educate the families associated with the 300 participating households involved in the study. Dissemination of the individual test results to tribal members began soon after the conclusion of the workshop.
- In June 2009, ATSDR's Division of Toxicology and Environmental Medicine (DTEM), with assistance from the CDC National Center for Health Marketing developed, recorded, and produced the Environmental Medicine Grand Rounds "Uranium for the Navajo Nation Health Clinics." The Grand Round reviews some of the history of uranium mining, uranium health effects and medical care, and provides some information on water sampling activities conducted by the NNEPA and NCEH. These materials support the work of NNEPA, NCEH, IHS, and EPA in addressing uranium contamination of Navajo land by past mining and milling activities. Past and ongoing exposure has negatively impacted the health of some tribal members.
  - Recognizing the difficulties in providing in-person, local training to widely dispersed health professionals and their staffs, the "Uranium for the Navajo Nation Health Clinics" Grand Rounds DVD was developed with a DTEM environmental medicine physician presenting critical information on uranium health effects to the health professionals caring for tribal members who may suffer health effects from exposure to uranium waste. This training product allows local physicians and their staffs the flexibility to receive continuing education at times and places convenient with their schedules and locations. This format provides additional opportunities to educate new staff and for all staff to use as a refresher to reinforce their learning experience. The "Uranium for the Navajo Nation





Health Clinics” Grand Rounds will be available on DVD to Navajo Nation clinics and health professionals. ATSDR offers free continuing education credits to physicians, nurses, and health educators who complete this Environmental Medicine Grand Rounds training and posttest as a service to assist these NN health professionals to maintain their medical and health credentials.

- ATSDR anticipates FY 2010 funds for ATSDR to conduct an Epidemiological Study at the NN. The ATSDR Division of Health Studies is projected to design and begin epidemiologic studies of health conditions caused by non-occupational exposures to uranium released from past mining and milling operations on the NN.
- Technical Support and Data Analysis for Ft. Wingate Army Base Closure and Transfer of Lands to the Navajo Nation and Pueblo of Zuni
  - The Fort Wingate Army Depot, located about eight miles east of Gallup, NM, closed in January 1993 after nearly a century and a half of military uses, first as a cavalry post, then as a munitions depot. Environmental investigation and cleanup efforts, including munitions clearance, have been made on a nearly continuous basis since 1994. Major environmental concerns at this site include munitions hazards and groundwater contamination by explosives and nitrates. On December 31, 2005, the New Mexico Environment Department's (NMED) RCRA permit came into effect, establishing a scheduled cleanup of the facility.
  - In November 2008, an ATSDR Site Remediation and Assessment Branch (SRAB) representative and the NCEH/ATSDR Tribal Liaison participated in a meeting with the US Army, NN representatives, Pueblo of Zuni representatives, and the NMED that was held in Gallup, NM. SRAB was asked to review various documents and to provide input on the environmental public health exposure pathways that have the potential to impact future land use options. The US Army is conducting a phased assessment of soil, water and other media in preparation for the transfer of lands to the Bureau of Indian Affairs (BIA) who will then facilitate the distribution of lands to the Navajo Nation and Pueblo of Zuni.
  - SRAB provided input to the Department of Defense (DOD) during 2009 on the sampling and risk assessment methodology for the site and continues to collaborate with the two tribes, the US Army, and NMED to ensure their environmental health concerns are addressed.



## Attendant Roster

### **Tribal Consultation Advisory Committee (TCAC) Members**

Chester Antone, Tucson, TCAC Chair (Tohono O'odham Nation, Councilman)  
Roselyn Begay, Navajo Nation (Division of Health, Program Evaluation Manager)  
Joe Finkbonner, Portland (Northwest Portland Area Indian Health Board, Executive Director)  
Reno Franklin, California (California Rural Indian Health Board, Chairman)  
Kathy Hughes, Bemidji, TCAC Co-Chair (Oneida Business Committee)  
Cynthia Manuel, NIHB (Tohono O'odham Nation, Councilwoman)  
Michael Peercy, Tribal Self-Governance Advisory Committee, Choctaw Nation of Oklahoma,  
Epidemiologist  
J.T. Petherick, Oklahoma (Cherokee Nation, Health Legislative Officer)  
Alicia Reft, Alaska (Karluk Ira Tribal Council)  
Dee Sabattus, Nashville (United South and Eastern Tribes, Inc., Interim THPS Director)  
Lester Secatero, Albuquerque (Albuquerque Area Indian Health Board, Chairman)  
Roger Trudell, Aberdeen (Santee Sioux Tribe of Nebraska, Chairman)  
Derek Valdo, NCAI (from Pueblo of Acoma, National Congress of American Indians)

### **Other Elected Tribal Leaders**

Cathy Abramson, Sault Tribe of Chippewa Indians, Board Member  
Candida Hunter, Hualapai, Councilwoman  
Joyce Jones, Karluk IRA Tribal Council, Vice-President  
Andy Joseph, Jr., Colville Tribes, Northwest Portland Area Indian Health Board Chair, HHS  
Chair Tribe Council, NIHB  
Buford L. Rolin, Poarch Band of Creek Indians, Tribal Chairman

### **Other Tribal Organizations / Tribal Health Boards / Tribal Health Professionals**

Stacy Bohlen, NIHB, Executive Director  
Michael Bristow (Osage Tribe of Oklahoma)  
Jessica Burger, NIHB, Deputy Director  
Bridget Canniff, Northwest Portland Area Indian Health Board, Tribal Epi Center Consortium,  
Project Director  
Kristal Chichlowska, Colville Confederated Tribes, California Tribal Epidemiology Center,  
Director  
Alan Crawford (former AI CDC employee)  
Feliciano Cruz, Pascua Yaqui Tribe, Public Health Emergency Preparedness Coordinator  
Larry Curley, Indian Health Board of Nevada, Executive Director  
Elaine Dado, Northwest Portland Area Indian Health Board  
Maria Garcia, Pascua Yaqui Tribe, Program Manager Alternative Medicine  
Tim Gilbert, Alaska Native Tribal Health Consortium, Senior Director, Community Health  
Kristin Hill, Great Lakes Inter-Tribal Epidemiology Center, Director  
Lyle Ignace, Coeur D'Alene, Indian Health Service, Medical Officer  
Luke Johnson, Fort Mojave Indian Tribe, Public Health Emergency Preparedness Coordinator  
Angela Kaslow, CRIHB, Director, Family and Community Health Services  
Deborah Klaus, Navajo Division of Health, Director / Senior Epidemiologist, Navajo Epi Center



Steven Matles, Indian Health Board of Nevada, Deputy Director  
Jackie McCormick, Northwest Portland Area Indian Health Board  
Ruth Ojanen, Board Member, Norton Sound Health Corporation  
Michael Peercy, Choctaw Nation of Oklahoma, Epidemiologist  
Geoffrey Roth, National Council of Urban Indian Health, Executive Director  
Paul Saufkie, Hopi Tribe, Public Health Emergency Preparedness Coordinator  
Audrey Solimon, NIHB, Senior Advisor, Public Health Programs  
Berda Willson, Norton Sound Health Corporation, Board Secretary

### **Centers for Disease Control and Prevention**

Larry Alonzo, Commander, US Public Health Service  
Annabelle Allison, Environmental Health Specialist, NCEH / ATSDR  
Lynda Anderson, DACH / NCCDPHP / CDC  
Mick Ballesteros, Associate Director for Science, National Center for Injury Prevention and Control  
Holly Billie, Senior Injury Prevention Specialist, National Center for Injury Prevention and Control  
Nell Brownstein, AREB/DHDSR/NCCDPHP/CDC  
Kristen Brusuelas, Chief of Government Relations, State and Local Services  
Ralph Bryan, Senior Tribal Liaison for Science and Public Health  
Pyone Cho, Epidemiologist, NCCDPHP  
Alex Crosby, Epidemiologist, Division of Violence Prevention, NCIPC  
Linda Crossett, DASH/NCCDPHP/CDC  
Larry Cseh, ATSDR, Environmental Health Scientist  
Sean Cucchi, Associate Director for Policy, NCCDPHP  
Rob Curlee, Deputy Director, Financial Management Office  
Lori de Ravello, IHS / Division of Epidemiology & Disease Prevention, Public Health Advisor  
Roseanne Farris, NCCDPHP / DNPAO, Branch Chief  
Michael Franklin, Senior Public Health Analyst, Financial Management Office  
Larry Gilbertson, Public Health Advisor, NCCDPHP  
Wayne Giles, Acting Deputy Director, National Center for Chronic Disease Prevention and Health Promotion  
William Kohn, DDS, Director, DOH/NCCDPHP/CDC  
Christine Kosmos, Director, Division of State and Local Readiness  
Dianne May, PSB/OSH/NCCDPHP/CDC  
Marcus Plescia, Director, DCPC/NCCDPHP/CDC  
Dawn Satterfield, Native Diabetes Wellness Program  
Mike Snesrud, Senior Tribal Liaison for Policy and Evaluation  
Stephen Thacker, Acting Deputy Director, Office of Surveillance, Epidemiology, and Laboratory Services  
Myra Tucker, Tribal Liaison  
Karen White, Acting Deputy Director, Office of State and Local Support  
Lorraine Whitehair, Division of Nutrition, Physical Activity, and Obesity / NCCDPHP  
Craig Wilkins, AI/AN Team  
Walter Williams, Office of Minority Health and Health Disparities



**Other Guests**

Stacey Ecoffey, Principal Advisory for Tribal Affairs, Intergovernmental Affairs, HHS  
Brenda Granillo, Director, Arizona Center for Public Health Preparedness  
Ronald Demaray, IHS, Acting Director, Office of Direct Service and Contracting with Tribes

